

759

CERTIFICATE OF DEATH

Reg. Dist. No. 00754

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg				c. LENGTH OF STAY IN 1b 9 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattstown Mill Rd.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paul Middle Bateman Last Allender				4. DATE OF DEATH Month January Day 27 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28, 1878	
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Fallston, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Lawrence Allender				14. MOTHER'S MAIDEN NAME Charlotte Cloman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-16-7787			
17. INFORMANT Mr. Bird Jacquette Allender, Item 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 10, 1947, to January 27, 1961, that I last saw the deceased alive on January 26, 1961, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1/27/61							
ACTUAL SIGNATURE James P. Kerr				M.D. Damascus, Md.			
PHYSICIAN'S NAME (Type) James P. Kerr				Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF JAN. 31		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Rane				24a. REC'D BY REGISTRAR Feb 2 '61			
ADDRESS Church Hill, Md.				24b. REGISTRAR'S SIGNATURE William S. Rane			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page #

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
750
CERTIFICATE OF DEATH

00755

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 6 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 1709 S. Taylor Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH Month January Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-61
9. AGE (In years last birthday) 5		10. IF UNDER 1 YEAR Months 5 Days 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kenneth F. ANDREWS		14. MOTHER'S MAIDEN NAME Ruth Ann HOEHLEIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Kenneth F. Andrews, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal Atelectasis 762-5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the hospital attended the deceased from Jan. 23 19 61 to Jan. 24 19 61 that (I) was last saw the deceased alive on Jan. 24 19 61 , and that death occurred at 2:35 AM M, from the causes and on the date stated above.			
22a. SIGNATURE Fred W. Grelio		22b. DATE SIGNED 1-24-61	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELIO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 1-26-60	
23c. NAME OF CEMETERY OR CREMATORY Oak Grove		23d. LOCATION (City, town, or county) (State) Conway Arkansas	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		25a. REC'D BY REGISTRAR JAN 26 '61	
ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

761 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00756

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 5930 Kirby Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5930 Kirby Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JACK LAWRENCE ARMSTRONG, JR.				4. DATE OF DEATH January 27 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21, 1947	
9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jack Lawrence Armstrong	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Audrey Bloom		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO.		17. INFORMANT Jack Lawrence Armstrong - Father - Same #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to hanging 936.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging from rope			
20c. TIME OF INJURY Month, Day, Year 12:10 p.m. Jan. 27 1961				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home				20f. (City or town) Bethesda, Montgomery, Md. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty				M.D. CHARLES S. PETTY, M. D.			
EXAMINER'S NAME (Type) CHARLES S. PETTY, M. D.				DATE SIGNED 1/29/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/31/61			
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem				22d. LOCATION (City, town, or country) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR FEB 2 '61			
24b. REGISTRAR'S SIGNATURE Charles S. Petty							

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60757

762

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 271 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Darrell Middle James Last Ashley				4. DATE OF DEATH Month January Day 28 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1934	
9. AGE (In years last birthday) 26 yrs.		10. IF UNDER 1 YEAR Months 12 Days X Hours 2		11. IF UNDER 24 HRS. Hours 12 Min. 00		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body & Fender Repairman				10b. KIND OF BUSINESS OR INDUSTRY Shop		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Arthur C. Ashley				14. MOTHER'S MAIDEN NAME Mollie Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) YES Korean				16. SOCIAL SECURITY NO. 246-44-9503			
17. INFORMANT The Medical Records				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Testicular choriocarcinoma 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from May 2, 1960 to January 28, 1961 that (I) (we) last saw the deceased alive on January 28, 1961 and that death occurred at 9:05 AM from the causes and on the date stated above.			
22a. SIGNATURE <i>Martin Nydick M.D.</i>				22b. DATE SIGNED 1/28/61		22c. PHYSICIAN'S NAME (Type) Martin Nydick M.D.	
22d. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Jan 31/61				23c. NAME OF CEMETERY OR CREMATORY BE AIR Memorial Gardens		23d. LOCATION (City, town, or county) (State) Bel Air Harford Md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph W. Foster</i>				25a. REC'D BY REGISTRAR W. Broadway Williams St.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
25c. DATE JAN 31 '61				25d. ADDRESS Bel Air, Maryland			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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Journal of Management Studies, 20(6), 791-807.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

763 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00758

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1015 Spring St</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8504 16th St. NW</u> d. STREET ADDRESS <u>1 Silver Spring md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Vivian</u> Middle <u>Anslander</u> Last <u>Anslander</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>10</u> Year <u>1961</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Dec 25 1905</u>		
9. AGE (In years last birthday) <u>55</u> yrs.			10. IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>		
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			12. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		
13. FATHER'S NAME <u>Joseph Fleisher</u>			14. MOTHER'S MAIDEN NAME <u>Rose</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give year or dates of service)		
17. INFORMANT <u>Mr. William Selen/Kor</u>			Address <u>5806 Clover Rd. Balt. 15-Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>THROMBOSIS, POSTERIOR CORONARY ARTERY</u> DUE TO (c) <u>CORONARY ARTERIOSCLEROSIS, SEVERE</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>42001</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapse after receiving 1cc 2% Xylocaine for dental repair</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.					
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county) <u>1-11-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>					
22b. DATE THEREOF <u>1-12-61</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Shaare Tefloah</u>					
22d. LOCATION (City, town, or country) (State) <u>Balto Md</u>					
23. FUNERAL DIRECTOR <u>Jack Kurok</u> ADDRESS <u>2100 Eutaw Place</u>					
24a. REC'D BY REGISTRAR <u>JAN 13 '61</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

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EXAMINER'S CERTIFICATE OF DEATH

DATE

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PLACE

CAUSE

MANNER

AGE

SEX

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RESIDENCE

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10759

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>28 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>13412 Parkland Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Michael Balassa, SR.</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/24/94</u>		9. AGE (In years last birthday) <u>66</u> yrs	10. IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min <u>66</u>	11. IF UNDER 24 HRS Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min <u>66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam engineer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Allies Inn Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>MICHAEL BALASSA</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>170-10-6623</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Suppurative Empyema</u> <u>27.0</u> DUE TO <u>Massive Collapse lung (Surgical intervention)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Severe pneumonia</u> DUE TO <u>Severe pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u> <u>3 wks.</u> <u>20-30 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 31, 1960</u> to <u>Jan 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 28, 1961</u> and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond O. West</u>				22b. ADDRESS <u>SILVER SPRING, MD.</u>		22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Mem. Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

I

2

1



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

765

CERTIFICATE OF DEATH

00760

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN (b) <u>1</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>176 Woodlawn Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNE</u> Middle <u>L.</u> Last <u>BANGS</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>12, 1906</u>		9. AGE (In years, last birthday) <u>54</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Wiley Lyford</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Prescott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>3-10-3025</u>	
17. INFORMANT <u>Chester</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> <u>4 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, notify medical examiner) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month <u>1</u> Day <u>1</u> Year <u>1961</u> Hour a.m. <u>19</u> p.m. <u>00</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Baltimore</u>		20g. (County) <u>Montgomery</u>	
20h. (State) <u>Maryland</u>		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1961</u> , to <u>Jan 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 1, 1961</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Ronald S. Fleischer</u>		22b. DATE SIGNED <u>1-1-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER</u>		22d. ADDRESS <u>405 SHERIDAN STR. HYATTSVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/4/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Park</u>		23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u>	
23e. ADDRESS <u>Baltimore 17 Md</u>		25a. REC'D BY REGISTRAR <u>Jan 3 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Max J. Tucker, Sons</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is not known, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
766 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

LG761

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Jan + Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Silver Spring</u> d. STREET ADDRESS <u>613 Guadalupe Avenue Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hugh Thomas Barrett</u>		4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1961</u>		5. SEX <u>M</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (gasoline OWNER)</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>51</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>		13. FATHER'S NAME <u>Mr. David L. Barrett</u>	
14. MOTHER'S MAIDEN NAME <u>Gertrude E. Barrett</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-36-5697</u>	
17. INFORMANT <u>Mr. Robert Barrett</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u> sudokus</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>	
22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Md.</u>		23. FUNERAL DIRECTOR <u>Francis J. Collins</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
24b. REGISTRAR'S SIGNATURE		24c. ADDRESS <u>3821-14th St NW, Wash. D.C.</u>		24d. DATE <u>JAN 30 '61</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

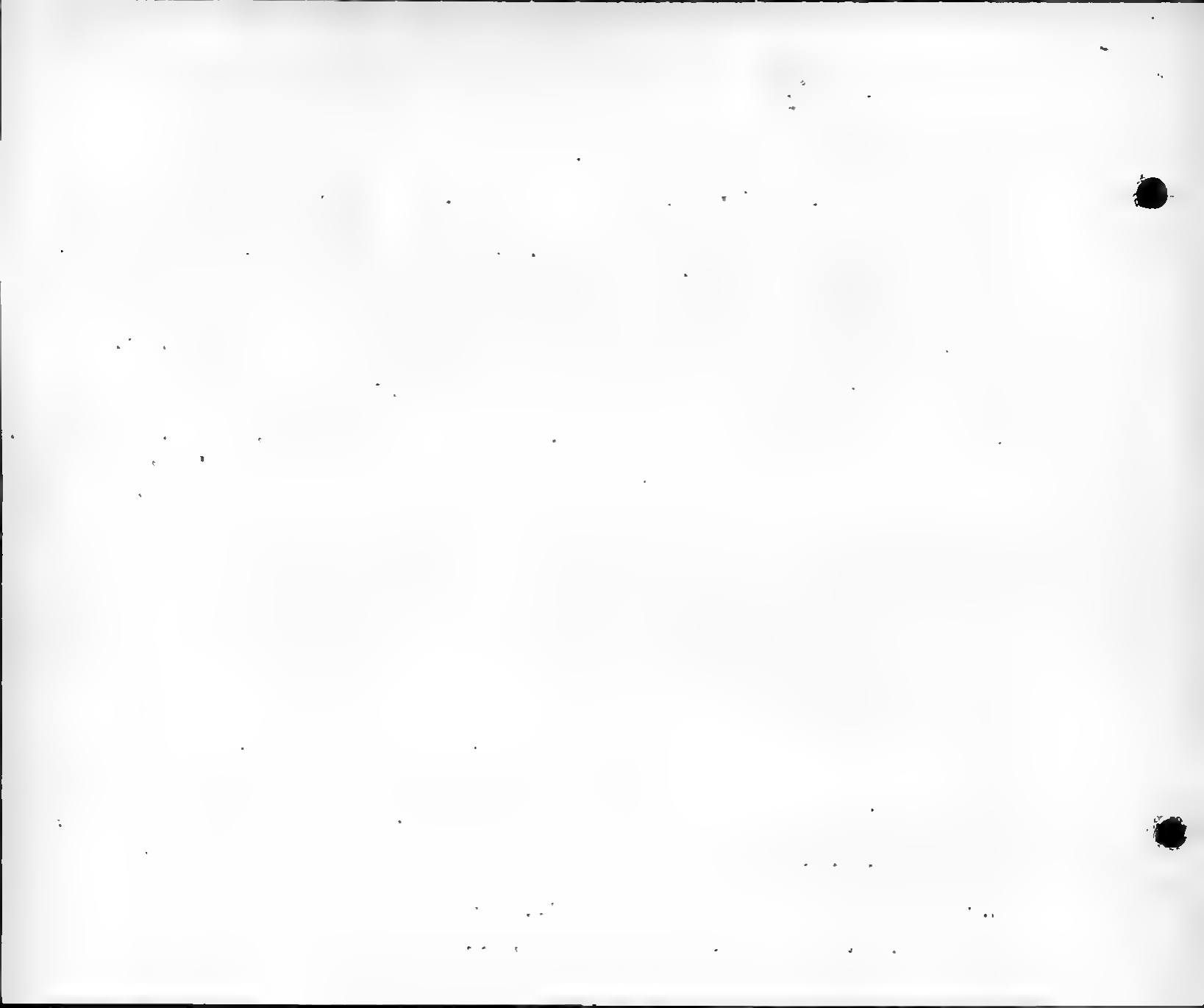
Reg. Dist. No.

60762

767

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN lb 23 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1543 N. Falkland Lane		2. USUAL RESIDENCE (Where deceased lived. If institution, give nearest town) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 1543 N. Falkland Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle LOCKHART Last BAYLOR		4. DATE OF DEATH Month JAN. Day 16 Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/84
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months 76	11. IF UNDER 24 HRS Days 76 Hours 76 Min. 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MONROE ROBINSON		14. MOTHER'S MAIDEN NAME MATTIE LOCKHART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Charles McIntosh Baylor, 1543 N. Falkland La.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO (b) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 331X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 10, 1943 , to January 16, 1961 , that I last saw the deceased alive on January 16, 1961 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 830 Pershing Drive, Silver Spring, Md. 20910 DATE SIGNED 1/17/61			
ACTUAL SIGNATURE W. B. WARDROP		PHYSICIAN'S NAME (Type) W. B. WARDROP	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/19/61	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE W. B. WARDROP, INC.		24a. REC'D BY REGISTRAR JAN 25 '61	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE John S. Kline	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



769

CERTIFICATE OF DEATH

Reg. Dist. No.

00763

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5047 Bradley Blvd</u>			
3. NAME OF DECEASED (Type or print) First <u>Sharon</u> Middle <u>Devise</u> Last <u>Bennett</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 3 1961</u>	9. AGE (In years last birthday) yrs. <u>17</u>	IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u>	IF UNDER 24 HRS Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Sub. Hosp. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Russell Norman Bennett</u>				14. MOTHER'S M maiden name <u>Anna Marie Devlin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Mother</u> Address <u>5047 Bradley Blvd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ATOLE CTASIS</u> <u>7x2.5</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>JAN 3</u> , 1961, to <u>JAN 4</u> , 1961, that I last saw the deceased alive on <u>JAN 4</u> , 1961, and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>1/9/61</u>							
ACTUAL SIGNATURE <u>Law. Peilman</u> M.D.				PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-5-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>				24a. REC'D BY REGISTRAR DATE <u>JAN 16 61</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

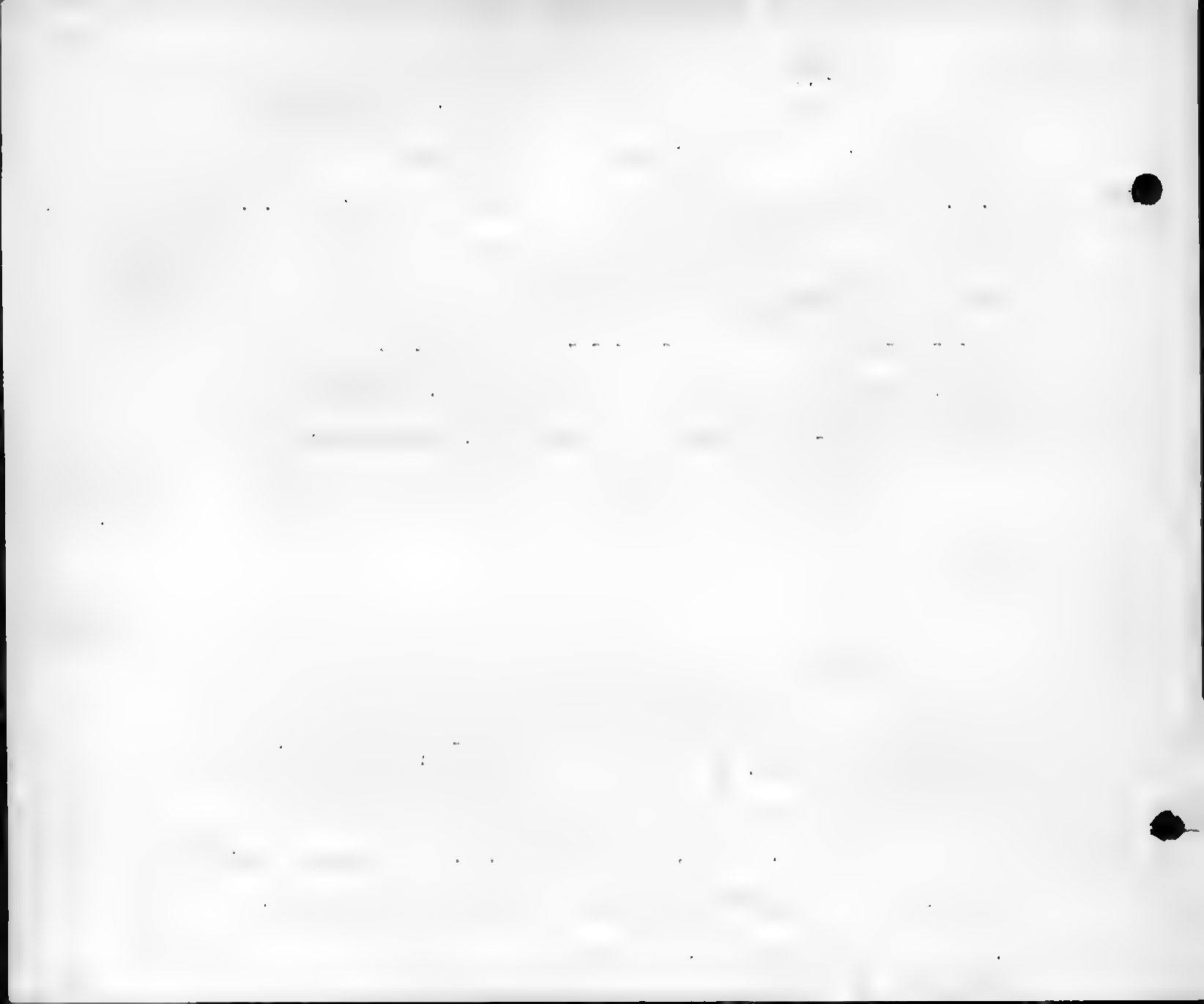
770

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66764

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 134 Madison Street, N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last Michael Raymond BIVENS				4. DATE OF DEATH Month Day Year January 16 19 61			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-15-61	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days 1		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ted E. BIVENS				14. MOTHER'S MAIDEN NAME Joyce A. FIGURSKI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Ted E. Bivens, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyland Membran Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 19 hrs. 27 1/2 h.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Birth 1-15-61 to Jan. 16, 1961, that (a) (we) last saw the deceased alive on Jan. 16, 1961, and that death occurred at 8:45 PM M, from the causes and on the date stated above.							
22a. SIGNATURE Lawrence G. Thorne M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-17-61	
22c. PHYSICIAN'S NAME (Type) Lawrence G. THORNE, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial-Shipment		1-17-61		Benet Chapel Cemetery		South Shore Kentucky	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JAN 19 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

2051202xv2



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

77 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

60765

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE 1 b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 N. Hollers Lane				d. STREET ADDRESS 10 N. Hollers Lane			
3. NAME OF DECEASED (Type or print) HARRY M. BOITON				4. DATE OF DEATH January 1, 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/25/1900	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 1 Days 1	IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1		10b. KIND OF BUSINESS OR INDUSTRY 1		11. BIRTHPLACE (State or foreign country) 1		12. CITIZEN OF WHAT COUNTRY? 1	
13. FATHER'S NAME John H. Boiton				14. MOTHER'S MAIDEN NAME Elizabeth John H.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1		17. INFORMANT Frances L. Enswiler-Itte # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 DUE TO (c) 1							INTERVAL BETWEEN ONSET AND DEATH 1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Bierbaum				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) J. Bierbaum				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/1/61		22c. NAME OF CEMETERY OR CREMATORY 1		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE 1 ADDRESS 1				24a. REC'D BY REGISTRAR 1		24b. REGISTRAR'S SIGNATURE 1	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



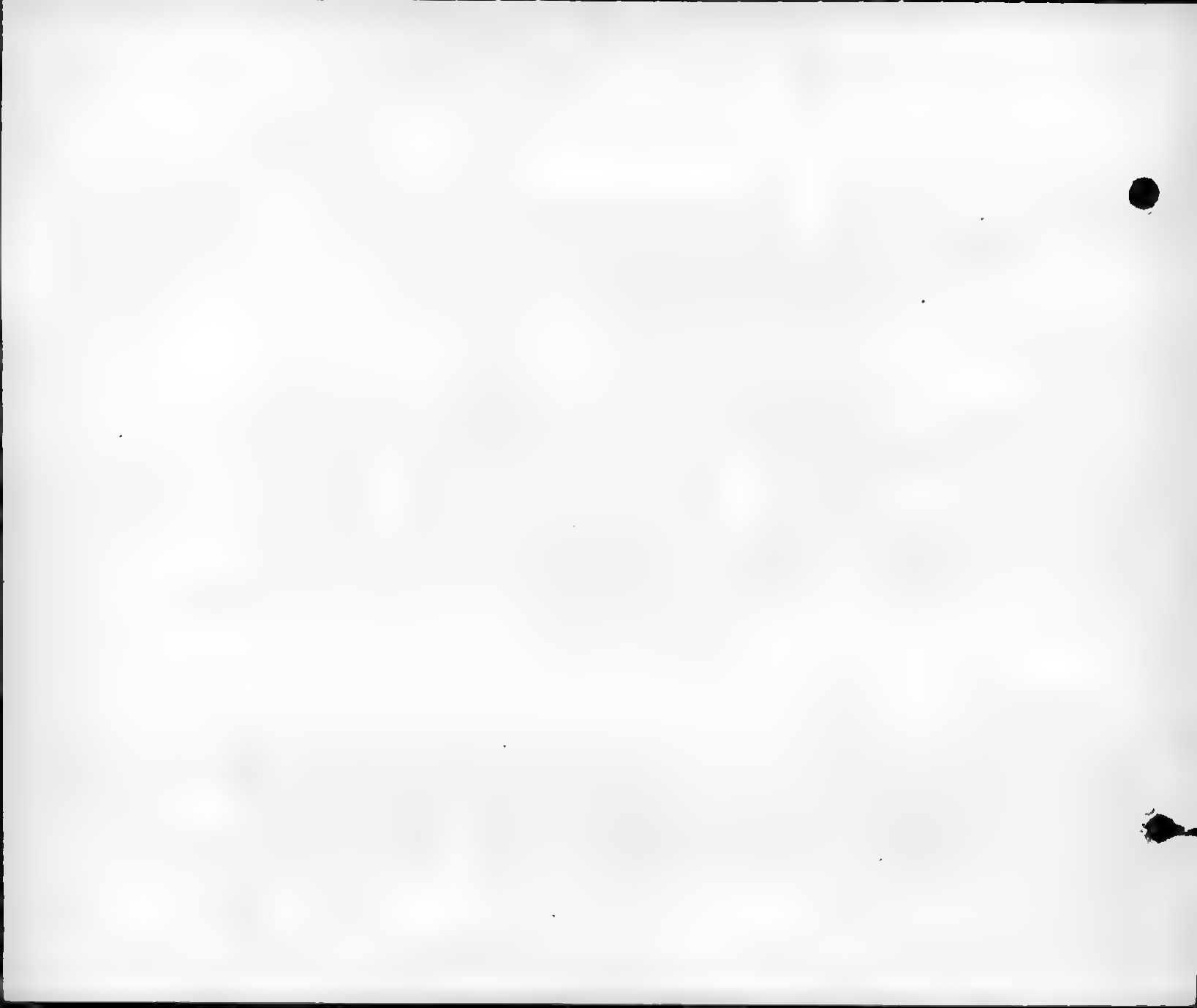
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

772

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66766

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>DC.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>2-yrs 9mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc.</u>				d. STREET ADDRESS <u>4751 Berkeley Terrace NW</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>John Wallace Brackett</u>				4. DATE OF DEATH Month Day Year <u>Jan. 6 1961</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Apr. 2, 1865</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11 BIRTHPLACE (State or foreign country) <u>Wis.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>M.D., retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)	
13 FATHER'S NAME <u>James Brackett</u>				14. MOTHER'S MAIDEN NAME <u>Luema Hamilton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>none</u>		17 INFORMANT Address <u>James R. Brackett 4751 Berkeley Terrace NW, DC.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Infection + Cocklefish</u> (c) <u>3 mo.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2da.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>9-10-1959</u> to <u>Jan 6-1961</u> , that (I) (we) lost saw the deceased alive on <u>Jan 1-1961</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above			
22a. SIGNATURE <u>Roy B. Parsons</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <u>Jan. 6, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROY B. PARSONS</u>				22d. ADDRESS <u>Burtonsville Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JAN 9 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Francis H. Barker Saytonville Md</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

773

00767

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sanitarium & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) _____ d. STREET ADDRESS <u>3210 Klinge Rd. NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCES Amelia Brining</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>9-28-1870</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSW</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Hyman</u> 14. MOTHER'S MAIDEN NAME <u>Weckler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of service) <u>no</u> 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Hosp record.</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> 31a } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>C-V-accident</u> (a), stating the underlying cause last. } DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) _____ 20f. City or town _____ (County) _____ (State) _____	
21. I certify that (I) (th's hospital) attended the deceased from <u>1949</u> to <u>Jan 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 2, 1961</u> , and that death occurred <u>6:25 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Hare</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>7600 Carroll Ave, Tak. PK. MD</u> 22b. DATE SIGNED <u>1/3/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u> 23d. LOCATION (City, town or county) <u>Boonsboro, Maryland</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> 25a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> DATE <u>JAN 5 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

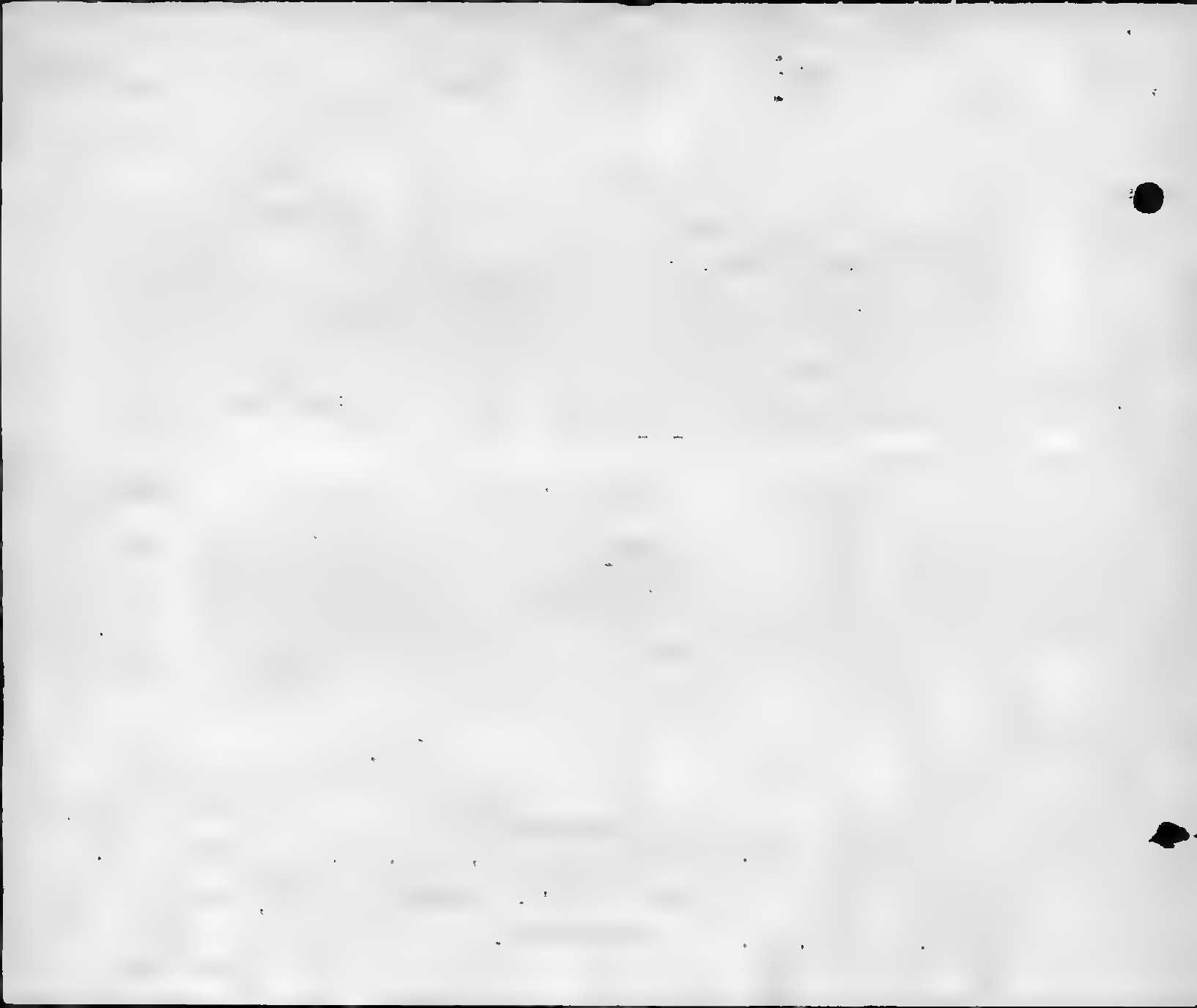
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

774

00768

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AROMA PARK</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington-Sinai-Samaritan Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2304 Perry Road</u>	
3. NAME OF DECEASED (Type or print) <u>Edessa Broderick</u> First <u>Edessa</u> Middle <u>Broderick</u> Last <u>Broderick</u>		4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25</u> <u>3 - 1922</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
13. FATHER'S NAME <u>Harry Newell</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Hackett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>439-24-9479</u>	
18. CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>125.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary edema</u> (c) <u>Myocardial infarction</u> <u>A.S.C.U.D.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part I of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County, (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1960, to Jan 30, 1961, that (I) (we) last saw the deceased alive on Jan 30, 1961, and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles M. Weber M.D.</u>		22b. ADDRESS <u>10,620 Ga. Ave., Silver Spring, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES M. WEBER</u>		22d. DATE <u>1/30/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/3/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>		23d. LOCATION (City town or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Ziska</u>		25a. REC'D BY REGISTRAR <u>DATE Feb 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>			

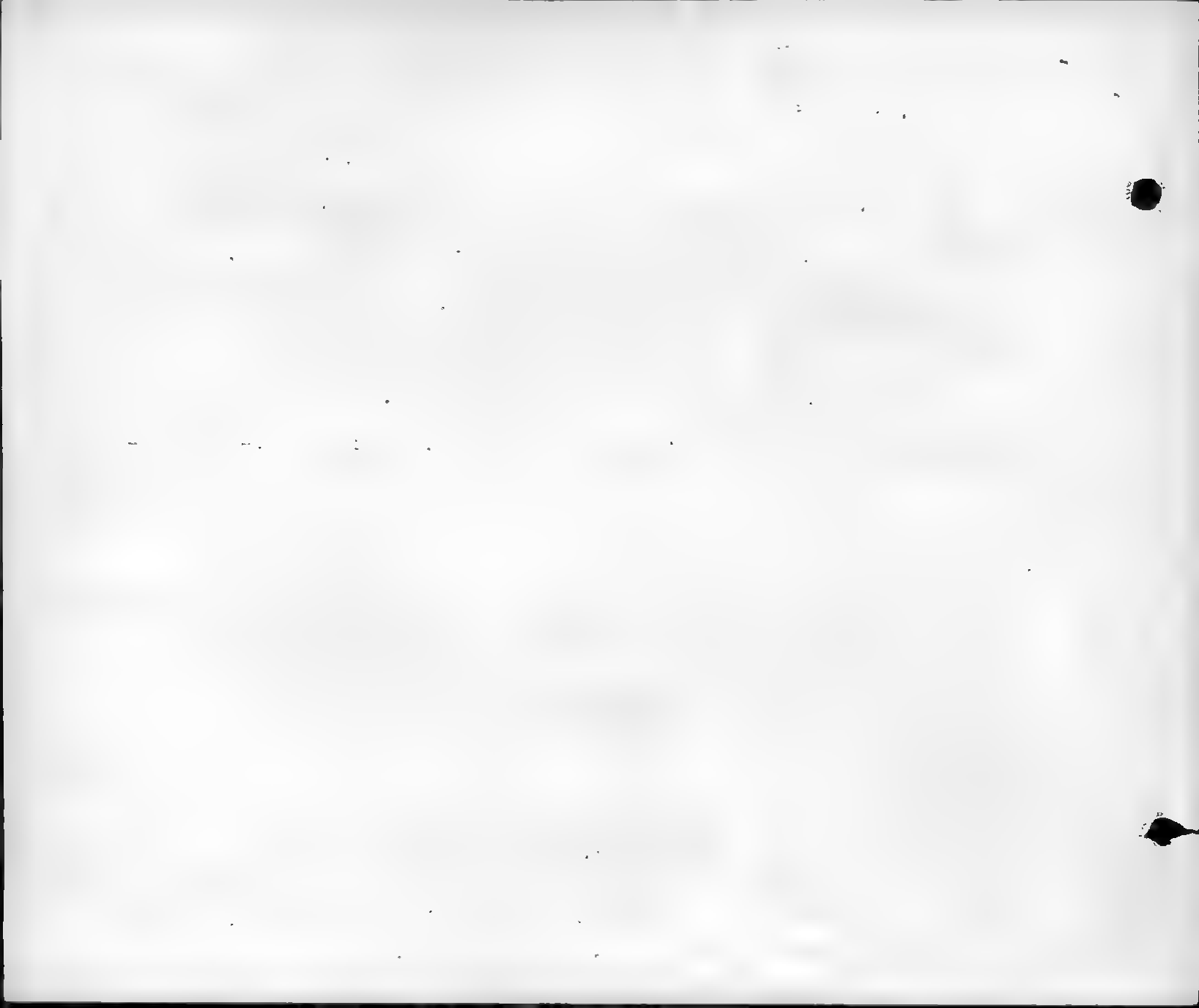


may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

775
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60769

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4102 Woodbine Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle Virginia Last Brooke				4. DATE OF DEATH Month Jan. Day 16 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1916	
9. AGE (In years last birthday) 44 yrs		IF UNDER 1 YEAR Months 6 Days 13		IF UNDER 24 HRS. Hours 13 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Francis C. Brooke				14. MOTHER'S MAIDEN NAME Mary A. Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Francis C. Brooke, Jr. - Brother - same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cirrhosis of Liver 581.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Seven hemorrhages (nose) DUE TO (c) Low blood clotting power -							INTERVAL BETWEEN ONSET AND DEATH 6 mo. 3 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 16, 1954 to Jan. 16, 1961 , that (I) (we) last saw the deceased alive on Jan. 13, 1961 and that death occurred at 5:40 AM , from the causes and on the date stated above.							
22a. SIGNATURE Gilbert B Rude				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/16/61	
22c. PHYSICIAN'S NAME (Type) Gilbert B Rude				22d. ADDRESS 3900 Military Rd. N.W. DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/18/61		23c. NAME OF CEMETERY OR CREMATORY Warrenton Cemetery		23d. LOCATION (City, town or county) (State) Warrenton, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JAN 18 '61	
				25b. REGISTRAR'S SIGNATURE <i>Conrad E. Jones</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

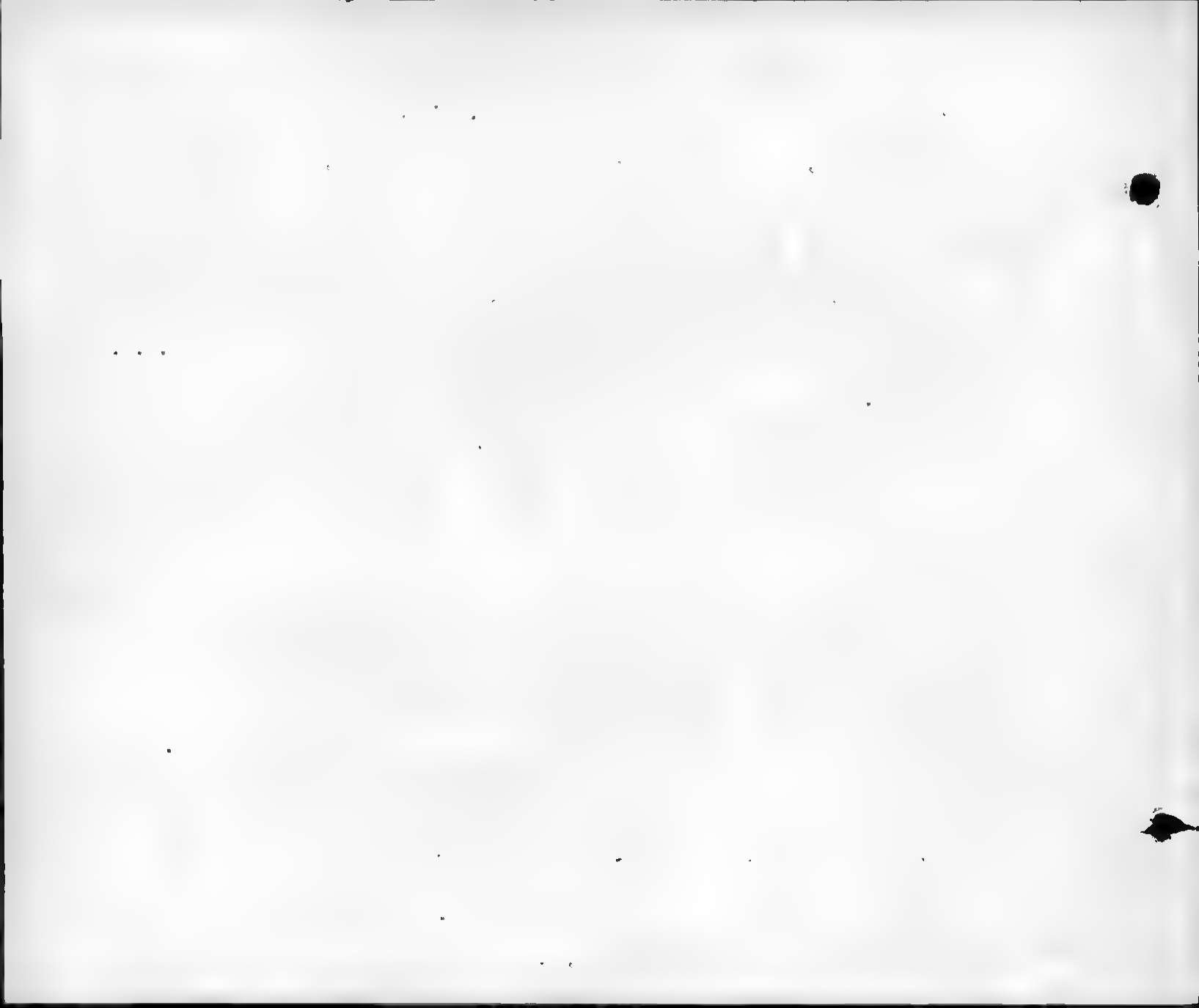
776

CERTIFICATE OF DEATH

02017

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Springs, Md</u>				c. LENGTH OF STAY IN 1b <u>30 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>Brooke Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>E.</u> Last <u>BROOKS</u>				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/4/1887</u>	9. AGE (In years last birthday) <u>73</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thomas H. Brooks</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Frances Hall</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Rosa A. Brooks (Same as above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion + Thrombosis +</u> <u>331X</u> DUE TO <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>EVD + Sen. Art. Sclerosis</u> DUE TO <u>Chronic passive cardiac failure</u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u> <u>3 yrs</u> <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>4 years</u> 19 <u>56</u> to <u>31 Jan</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>31 Jan</u> 19 <u>61</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John Bosley Ziegler</u> M.D.				22b. DATE SIGNED <u>3 Feb 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>	
22d. ADDRESS <u>OLNEY, MD</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>1/3/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Anand</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

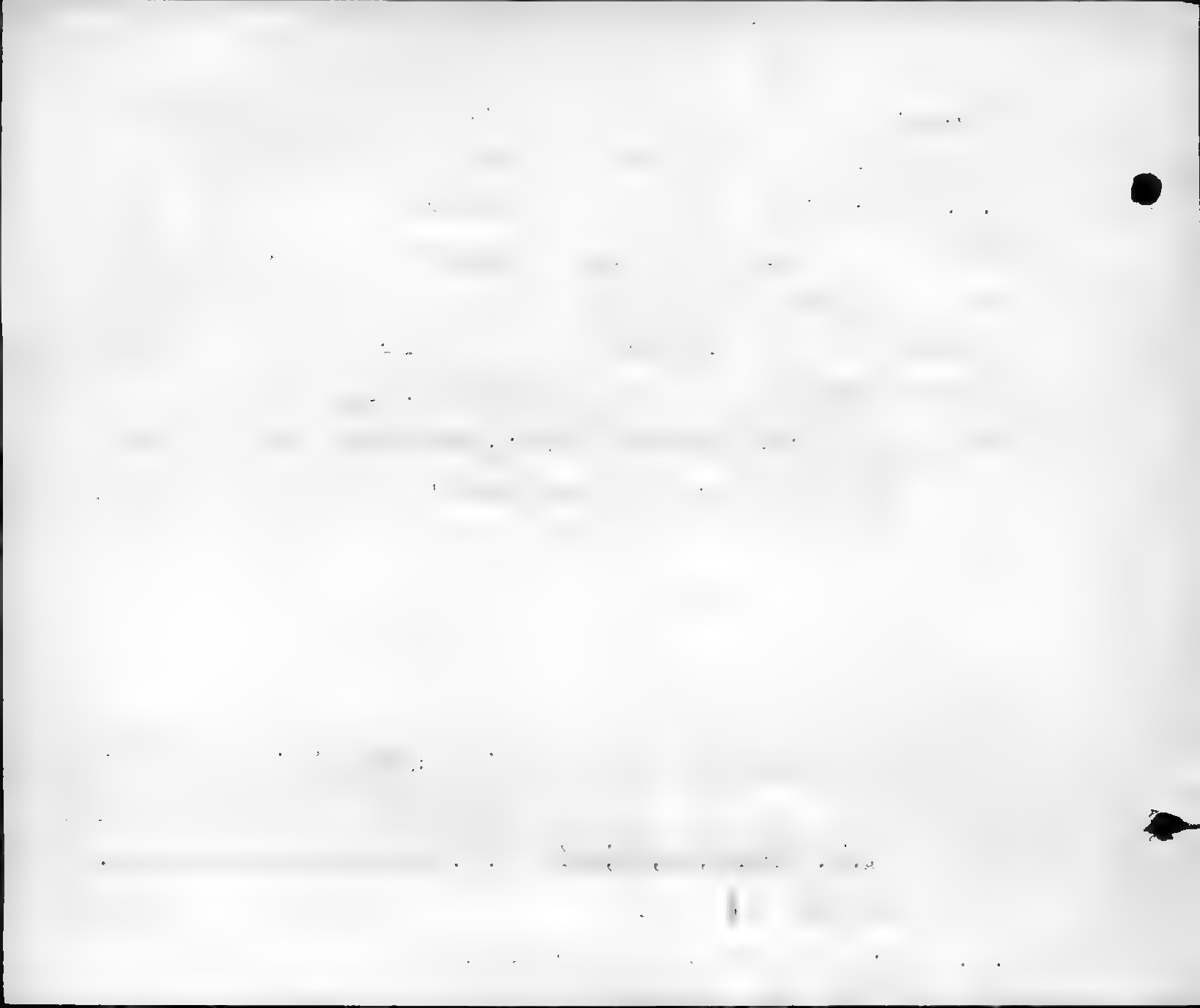
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton d. STREET ADDRESS Meadowbrook e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Allen Middle Ross Last BROUGHAM			4. DATE OF DEATH Month January Day 20 Year 19 61				
5 SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 6-1-13		9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 4 Days 10 Hours 15 Min 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) New York			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Herbert BROUGHAM			
14. MOTHER'S MAIDEN NAME Nettie I. HILL				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. 577-09-1309		17. INFORMANT Address (W) Mrs. Jane Brougham, same as #2 above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis, liver, Laennec's DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) _____ (State) _____			
21. I certify that he (this hospital) attended the deceased from Jan. 17 7:35AM to Jan. 20 1961 that he (we) last saw the deceased alive on Jan. 20 1961 , and that death occurred at _____ M., from the causes and on the date stated above.							
22a. SIGNATURE <i>M. William Voss</i>		22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22c. DATE SIGNED 1-21-61			
22c. PHYSICIAN'S NAME (Type) M. William Voss, LCDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 1-24-61		23c. NAME OF CEMETERY OR CREMATORY At sea			
23d. LOCATION (City town or county) Norfolk		23e. (State) Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE W. E. Pumphrey Funeral Home, Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE JAN 25 '61		25b. REGISTRAR'S SIGNATURE <i>Richard S. House</i>			

T. P. Hall makes the



778

CERTIFICATE OF DEATH

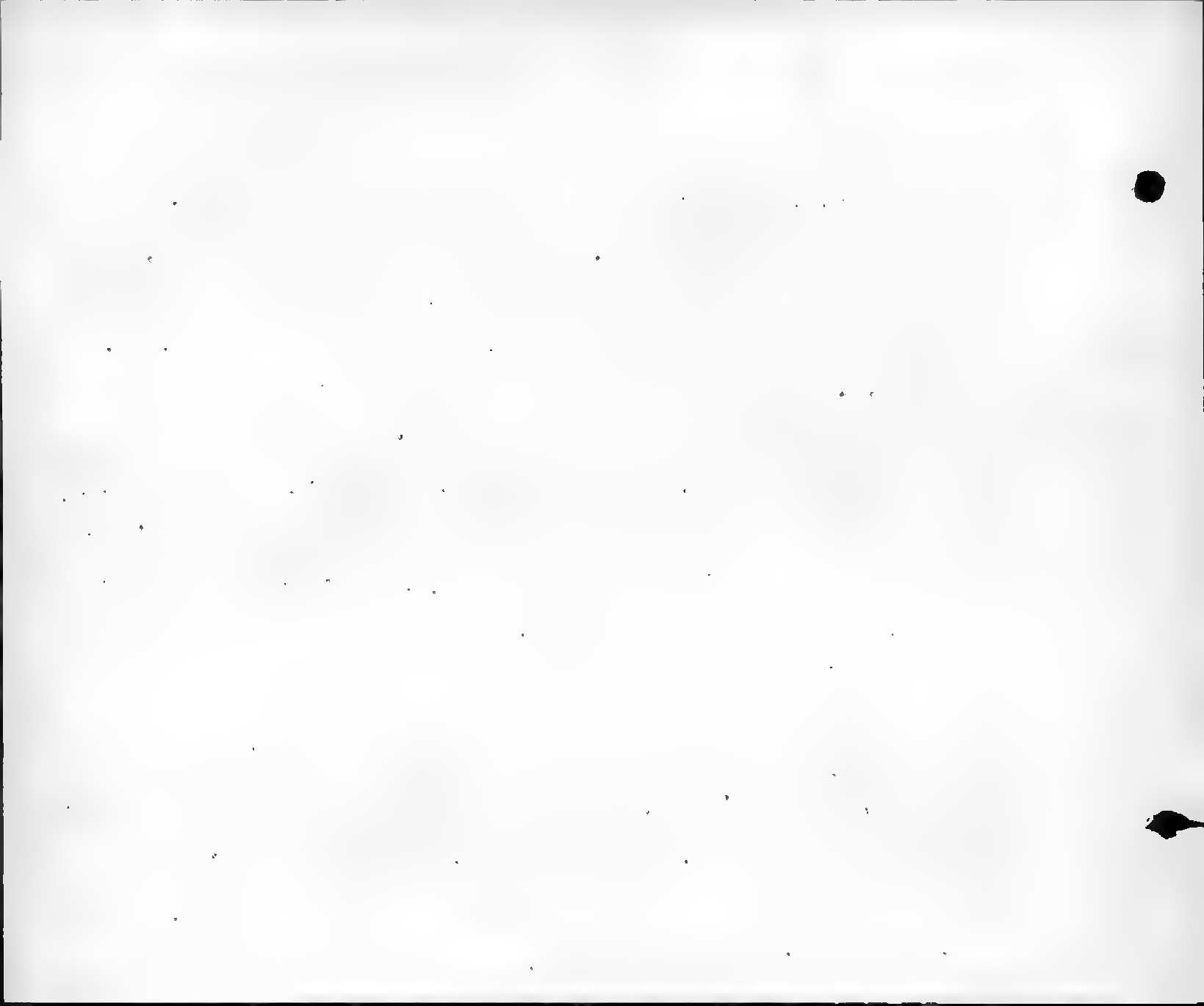
Reg. Dist. No.

60771

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY --			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10231 Carroll Place Carroll Hall Sanitarium				d. STREET ADDRESS 3002 Rodman Street, N.W.			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle K. Last Burch				4. DATE OF DEATH Month January Day 25 Year 19 61			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/8/1871	9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry C. Kraak				14. MOTHER'S MAIDEN NAME Wilhelmina Mueller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		INFORMANT Hospital Records--		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis, advanced DUE TO (c) Arteriosclerosis, generalised							INTERVAL BETWEEN ONSET AND DEATH 2 min 5 yrs + 10 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma, left breast 2 yrs +							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 1956 to 1-25-61 , that I last saw the deceased alive on 1-16-61 , and that death occurred at 8:25 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stewart Clapp		M.D. 4240 Chevy Chase Dr.		DATE SIGNED 1-25-61			
PHYSICIAN'S NAME (Type) Stewart Clapp M.D.		chevy chase 15 Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/1961		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W.				24a. REC'D BY REGISTRAR JAN 26 '61		24b. REGISTRAR'S SIGNATURE Stewart Clapp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

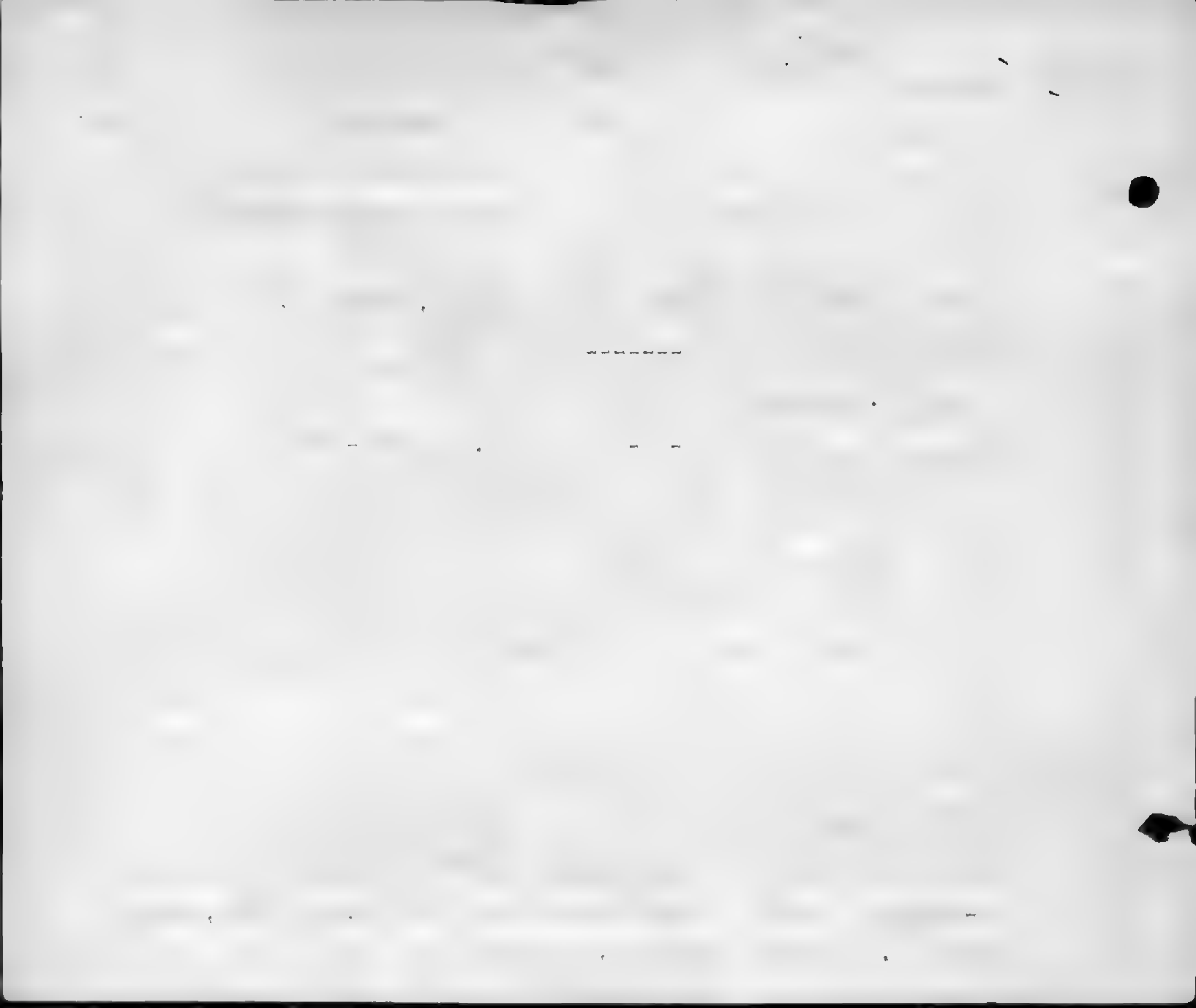
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66722

1. PLACE OF DEATH a. COUNTY <i>Montg</i>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		
c. LENGTH OF STAY N 16 <i>1 wk</i>			d. STREET ADDRESS <i>8800 Plymouth Street</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>5502 Glenwood Rd.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Elsie</i>			4. DATE OF DEATH Month <i>Jan</i> Day <i>17</i> Year <i>1961</i>		
5. SEX <i>Female</i>			6. COLOR OR RACE <i>White</i>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>April 13, 1893</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>Maine</i>		
10b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John M. McLaughlin</i>			14. MOTHER'S MAIDEN NAME <i>Libby (Unknown)</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>005-32-2387A</i>		
17. INFORMANT <i>Mrs. Barbour-daughter</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary occlusion</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED <i>1-17-61</i>					
ACTUAL SIGNATURE <i>Frank J. Blaszczak</i> M.D.					
EXAMINER'S NAME (Type) <i>FRANK J. Blaszczak</i>					
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)					
22b. DATE THEREOF <i>1/18/61</i>					
22c. NAME OF CEMETERY OR CREMATORY <i>Bab View Cemetery</i>					
22d. LOCATION (City, town, or country) (State) <i>S. Portland, Maine</i>					
23. FUNERAL DIRECTOR <i>Robert A. Pumphrey Bethesda, Maryland</i>					
24a. REC'D BY REGISTRAR <i>Arthur L. Hines</i>					
24b. REGISTRAR'S SIGNATURE					

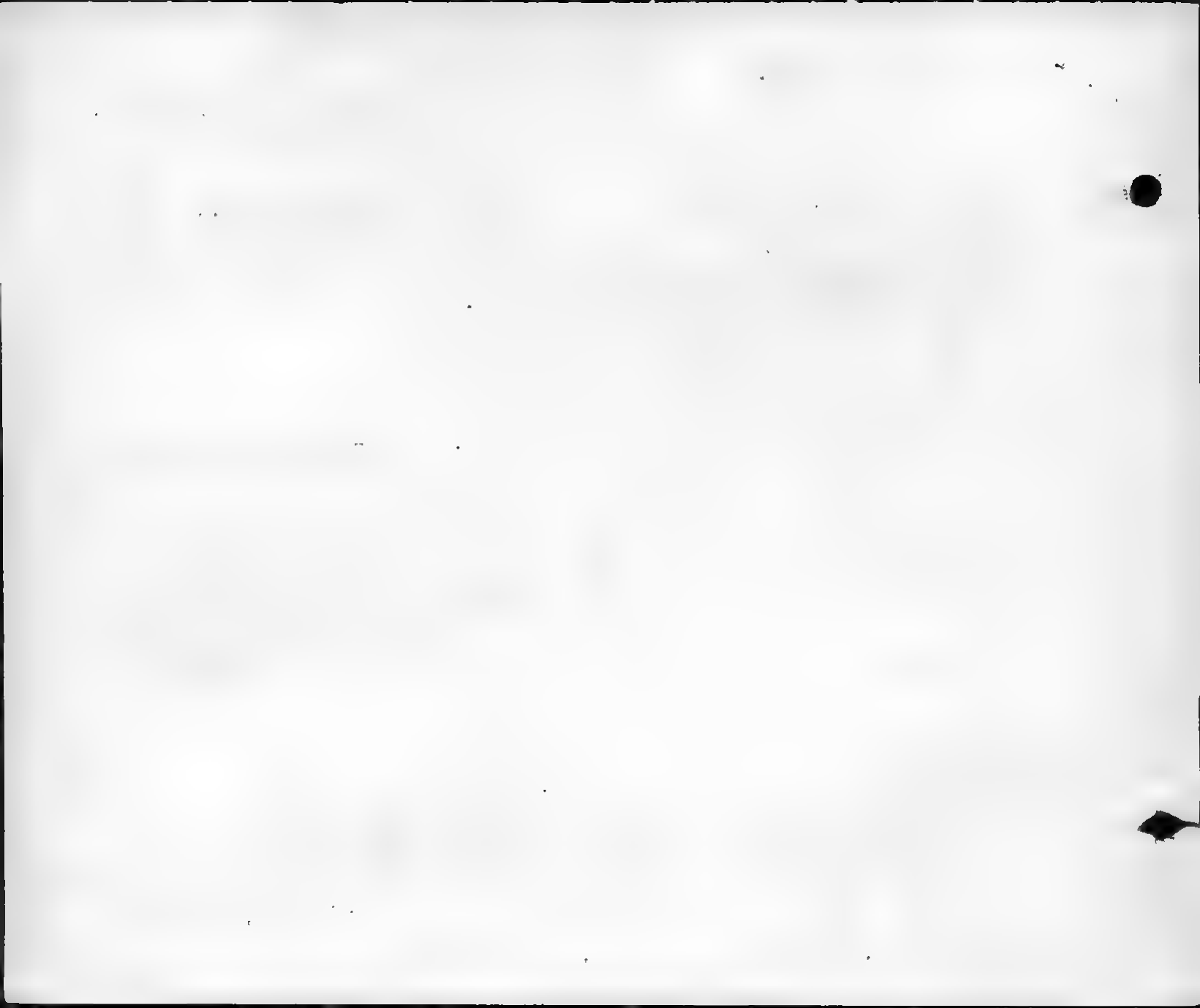


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

780

60773

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4616 Chevy Chase Blvd				d. STREET ADDRESS 4616 Chevy Chase Blvd., 1			
3. NAME OF DECEASED (Type or print) First Oliver Middle F Last Busby				4. DATE OF DEATH Month Jan Day 15 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1879	9. AGE (in years last birthday) 82 yrs	IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Busby				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Katie B. Busby-daughter-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/1/61 19 61 to 1/15 19 61 , that (I) (we) last saw the deceased alive on 1/15/61 19 61 , and that death occurred at 8:30 PM from the causes and on the date stated above							
22a. SIGNATURE Dr. J. Kenrick				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/15/61	
22c. PHYSICIAN'S NAME (Type) Dr. JOSEPH KENRICK				22d. ADDRESS 6451 W. Wisconsin Ave, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/17/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JAN 19 '61	
				25b. REGISTRAR'S SIGNATURE Clifford S. Pumphrey			

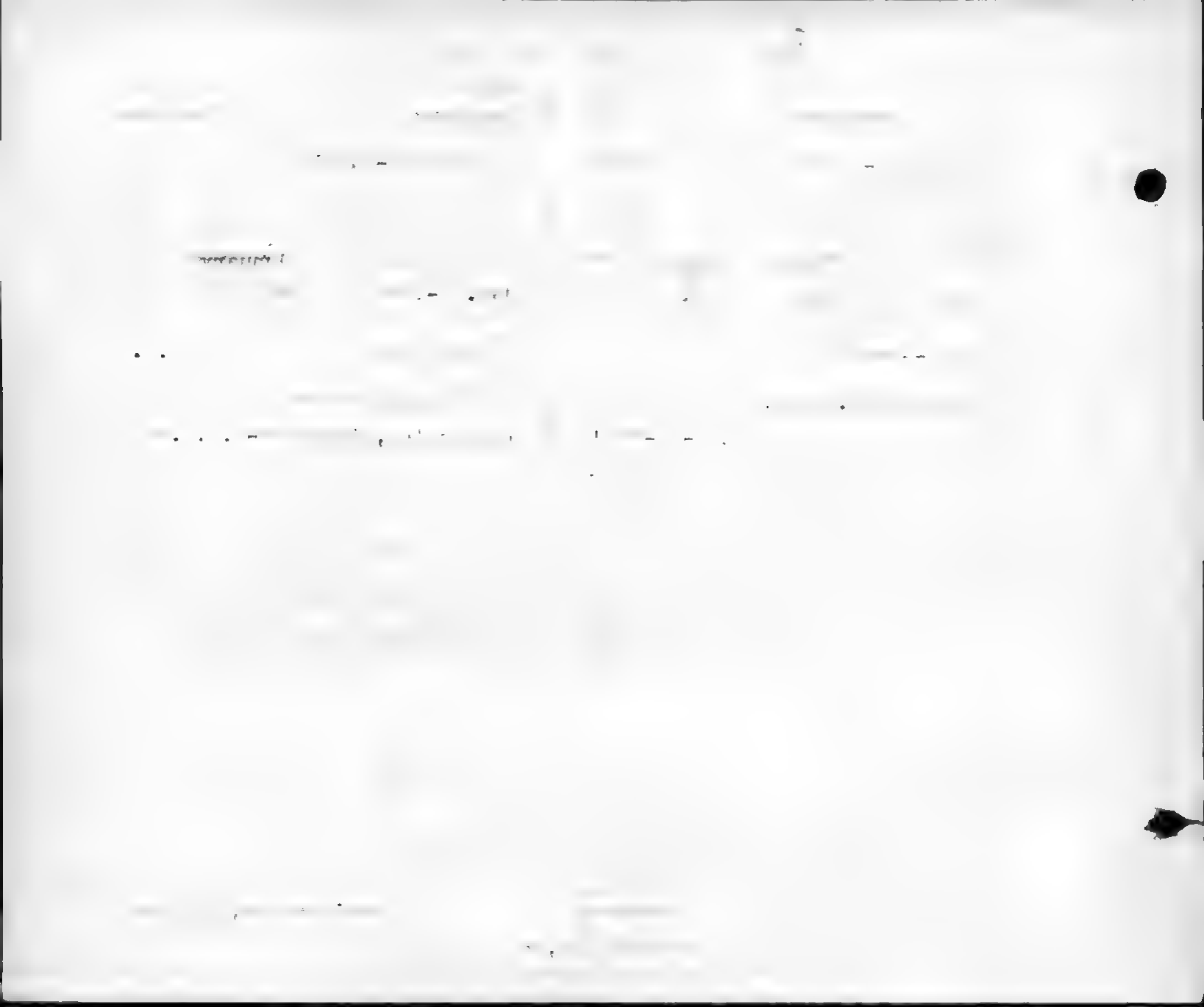


781
CERTIFICATE OF DEATH

Reg. Dist. No.

66774

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson---Rural				c. LENGTH OF STAY IN 1b 93 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Spates Last Butler				4. DATE OF DEATH Month January Day 20 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 11-1868	
9. AGE (In years last birthday) 93 yrs		F UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm--Owner				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Charles M. Butler				14. MOTHER'S MAIDEN NAME Frances Spates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-36-7274		INFORMANT Address George Butler, Dickerson-R.F.D. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 8 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia INTERVAL BETWEEN ONSET AND DEATH 1 day							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fractured femur				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 19 , 19 58 , to Jan 20 , 19 61 , that I last saw the deceased alive on Jan 19 , 19 61 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Vernon E. Martens M.D.				PHYSICIAN'S NAME (Type) Vernon E. Martens			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/24/61		22c. NAME OF CEMETERY OR CREMATORY Monocacy	
22d. LOCATION (City, town, or county) (State) Beallsville, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton				ADDRESS Barnesville, Md		24a. REC'D BY REGISTRAR DATE JAN 24 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							



782

CERTIFICATE OF DEATH

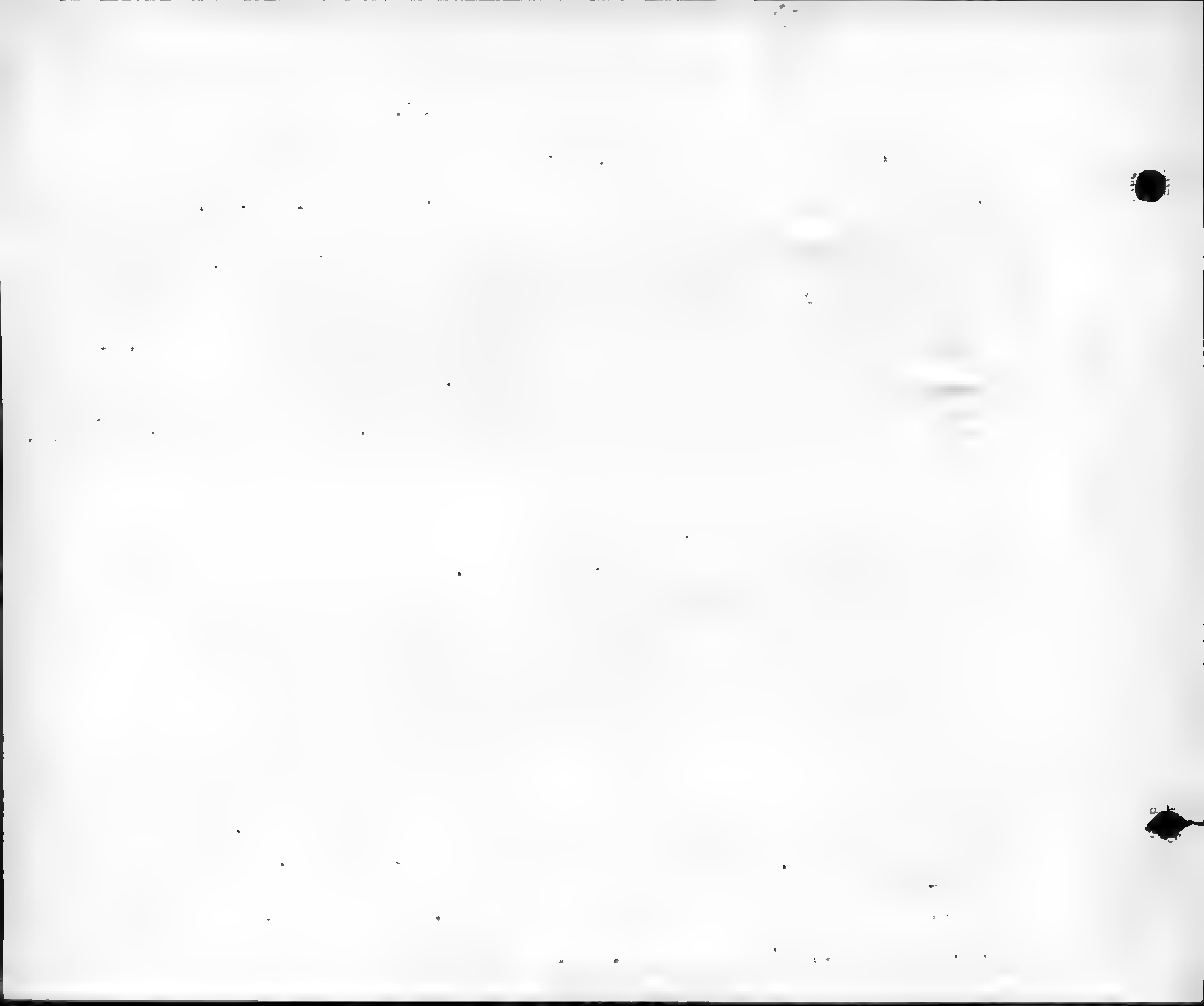
Reg. Dist. No.

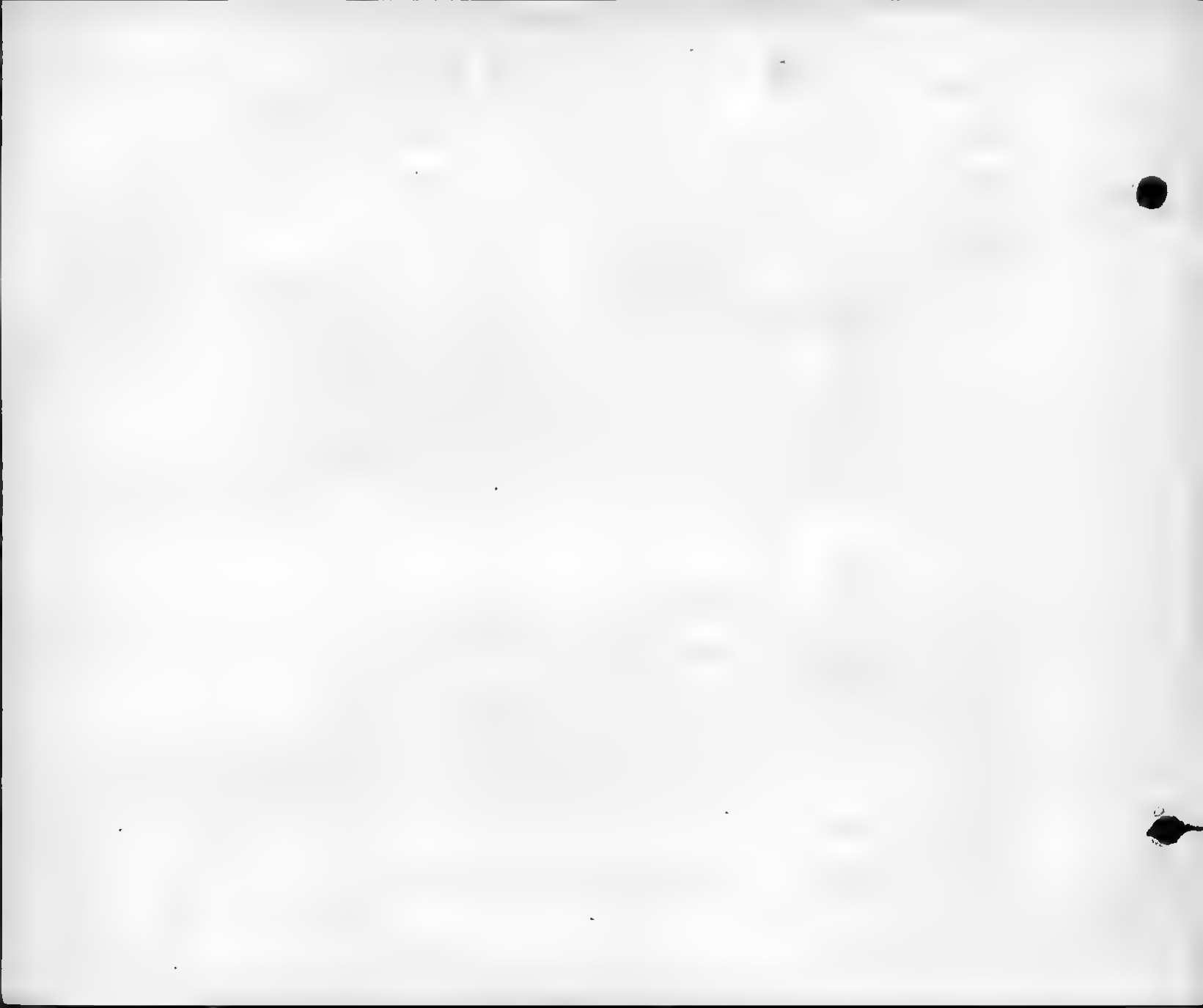
00775

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb 2xmas 1 yr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home		e. STREET ADDRESS 4627 Verplanck Place, N.W.	
3. NAME OF DECEASED (Type or print) First Jennie Middle Viola Last BYERS		4. DATE OF DEATH Month JANUARY Day 20 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1873
9. AGE (in years last birthday) 87 yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Dayton, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi .. Byers		14. MOTHER'S MAIDEN NAME Martha Snoke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT J. Harold Byers, 4627 Verplanck Pl, N.W.		Address Wash, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4-1-4X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV 11 , 19 59 , to JAN 20 , 19 61 , that I last saw the deceased alive on JAN 20 , 19 61 , and that death occurred at 5:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5206 Norway Dr DATE SIGNED 1/20/61 ACTUAL SIGNATURE Henry M. Lowden M.D. PHYSICIAN'S NAME (Type) Henry M. Lowden Cherry Chong, M.D.			
22a. BURIAL, CREMATION, REMOVAL, or other disposition burial		22b. DATE THEREOF 1/23/61	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines Co., 2901 14th St. N.W., Wash,		24a. REG'D BY REGISTRAR JAN 23 01	
ADDRESS D.C.		24b. REGISTRAR'S SIGNATURE W. S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

784

CERTIFICATE OF DEATH

00777

1. PLACE OF DEATH a. COUNTY <u>M. MONTGOMERY</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>				e. STREET ADDRESS <u>4530 AVONDALE ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>CERNIGLIA</u> Last <u>48</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 27 1884	
9. AGE (in years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (Country, state, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> 40 yrs	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Fronte</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Camilla Cerniglia</u> (Daughter Same as Above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u> 420.0 DUE TO <u>coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>arterio-sclerotic heart disease</u> (c) <u>acute congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>acute congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>5+ years</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1956</u> to <u>Jan 7 1961</u> that (I) (we) last saw the deceased alive on <u>Jan 7 1961</u> , and that death occurred at <u>8 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Willard R. Ehrmantraut</u>				22b. DATE SIGNED <u>1/7/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Willard R. Ehrmantraut M.D.</u>				22d. ADDRESS <u>4890 Battery Lane, Bethesda</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cem</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sherry Chase Funeral Home</u>				25a. REC'D BY REGISTRAR <u>JAN 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

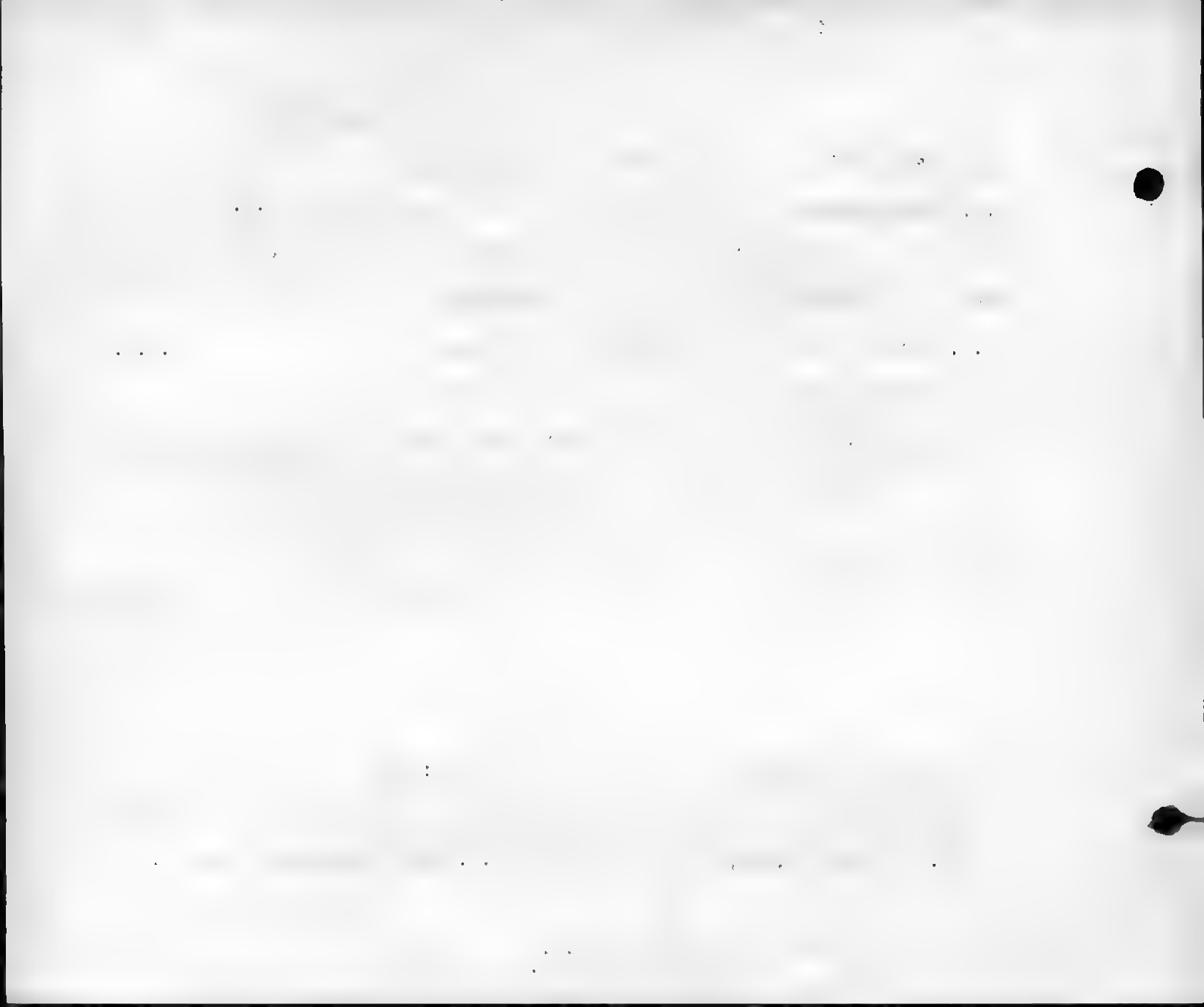
YR A15 (4)
15M 9/60



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 785
 CERTIFICATE OF DEATH

00778

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 103 Longfellow St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Edwin Last CLARK				4. DATE OF DEATH Month January Day 28 Year 1961			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-7-86	
9. AGE (In years last birthday) 74 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin James CLARK				14. MOTHER'S MAIDEN NAME Bertha Inez BURKE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO (If yes, give war or dates of service) WW I 579 09 9112		17. INFORMANT Mr. Philip Curtis, 708 Silver Spring, Mve. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial Infarction DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 min. 16 years							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-22- 1961 to 1-28- 1961 that (I) (we) last saw the deceased alive on 1-28- 1961 and that death occurred 4:13AM from the causes and on the date stated above							
22a. SIGNATURE William P. Baker				22b. DATE SIGNED 1-28-61		22c. PHYSICIAN'S NAME (Type) W.P. Baker, LT, MC, USN	
22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-1-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE LEE FUNERAL HOME, 4th & Mass. Ave. N.W. Washington, D.C.				25a. REC'D BY REGISTRAR JAN 31 '61		25b. REGISTRAR'S SIGNATURE Arthur S. House	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60779

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1915 Valley Stream Drive				d. STREET ADDRESS 1915 Valley Stream Drive			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle D. Last CLARK Jr.				4. DATE OF DEATH Month Jan. Day 26, Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1918		9. AGE (in years last birthday) 42 yrs.	IF UNDER 1 YEAR Months 3 Days 26	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William D. Clark				14. MOTHER'S MAIDEN NAME Carrie England			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W. W. II 217-03-2518		17. INFORMANT Address Mrs. Iva Clark-Wife-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m. 	Month, Day, Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Jan. 26, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/30/1961	22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) Rockville		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JAN 30 '61	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 must be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY <u>Montgomery</u>				a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
c. LENGTH OF STAY IN 1b <u>7 mo</u>				d. STREET ADDRESS <u>1 2609 Blue Ridge Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2609 Blue Ridge Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph E Coker</u>				4. DATE OF DEATH <u>Jan 11 1961</u>			
5. SEX <u>male</u> COLOR OF RACE <u>white</u>				6. DATE OF BIRTH <u>4-8-1903</u> 57 yrs.			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. AGE (in years) (IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court Guard of Retired</u>				11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>			
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Coker</u>				14. MOTHER'S MAIDEN NAME <u>Marie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give number or dates of service) <u>YES 1 L.I.I.</u>				16. SOCIAL SECURITY NO. <u>2-18-30-27</u>			
17. INFORMANT <u>Marie Coker (wife)</u> Address <u>Stun 2</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-11-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>1-13-61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hall</u>				22d. LOCATION (City, town, or country) (State) <u>7th Myer</u>			
23. FUNERAL DIRECTOR <u>W.W. Chambers Co</u> ADDRESS <u>1400 Chapin St N.</u>				24a. REC'D BY REGISTRAR <u>JAN 16 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			



CERTIFICATE OF DEATH

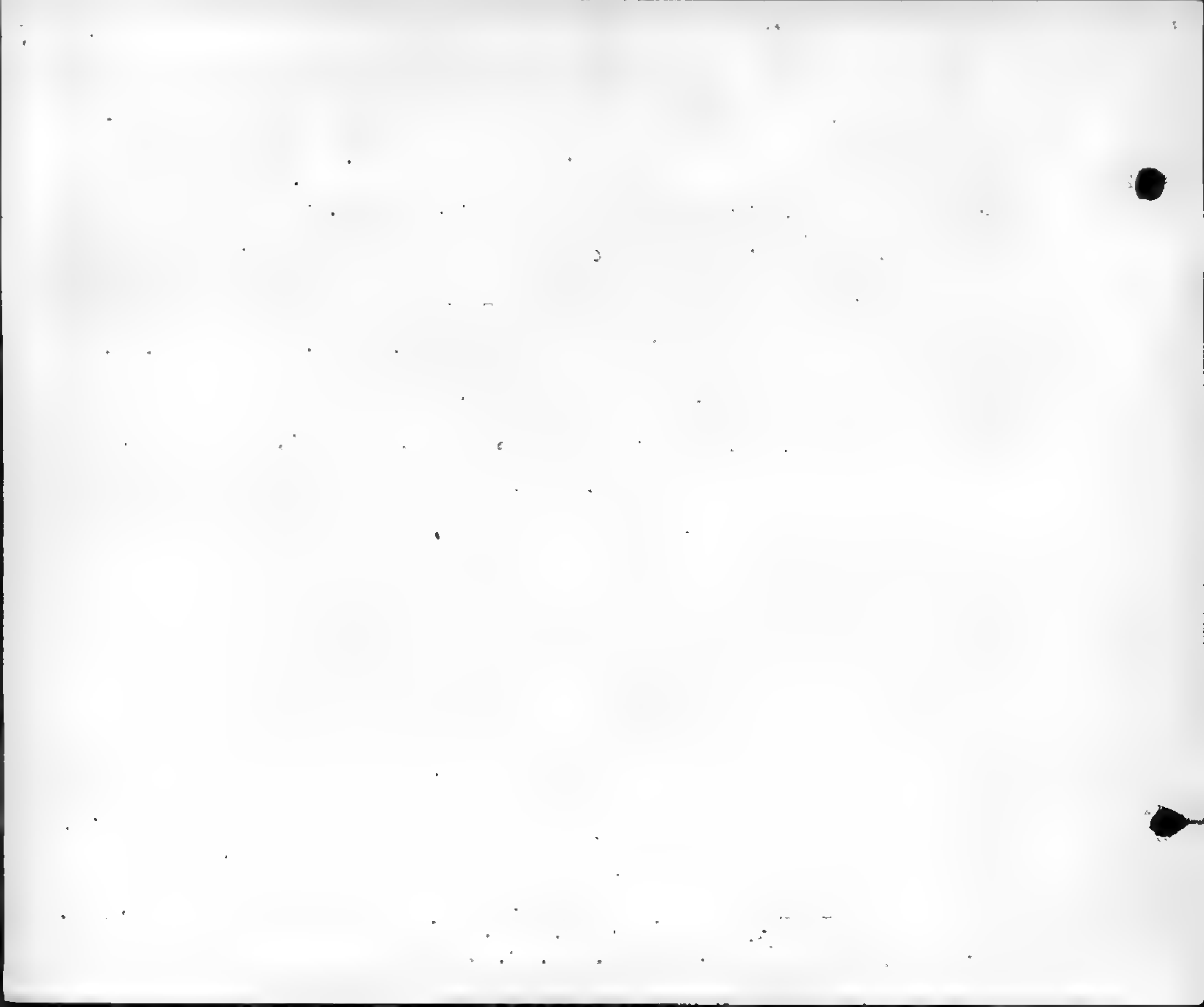
Reg. Dist. No.

60781

788

1. PLACE OF DEATH o. COUNTY <u>LONTG OMBRY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>THALLSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WAS. INGTON SANITARIUM HOSPITAL</u>		d. STREET ADDRESS <u>6602 24th. AVENUE</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK COLLELLI</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-94</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICE MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOBILE</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>RAFFAELA COLLELLI</u>		14. MOTHER'S MAIDEN NAME <u>FORTUNATA GRECO</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>218-20-1847</u>	
17. INFORMANT <u>CATHERINE V. COLLELLI</u>		Address <u>SALT AS "2"</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4-2-66 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>1 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/13</u> , 19 <u>57</u> , to <u>JAN 11</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>JAN 10</u> , 19 <u>61</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Norman Donat Comerak</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny ST</u>	
PHYSICIAN'S NAME (Type) <u>Norman Donat Comerak</u>		DATE SIGNED <u>1/11/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-14-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Gallino</u> ADDRESS <u>WASH. D.C.</u>		24a. REC'D BY REGISTRAR <u>JAN 16 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles L. Anna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 and 2 should be filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

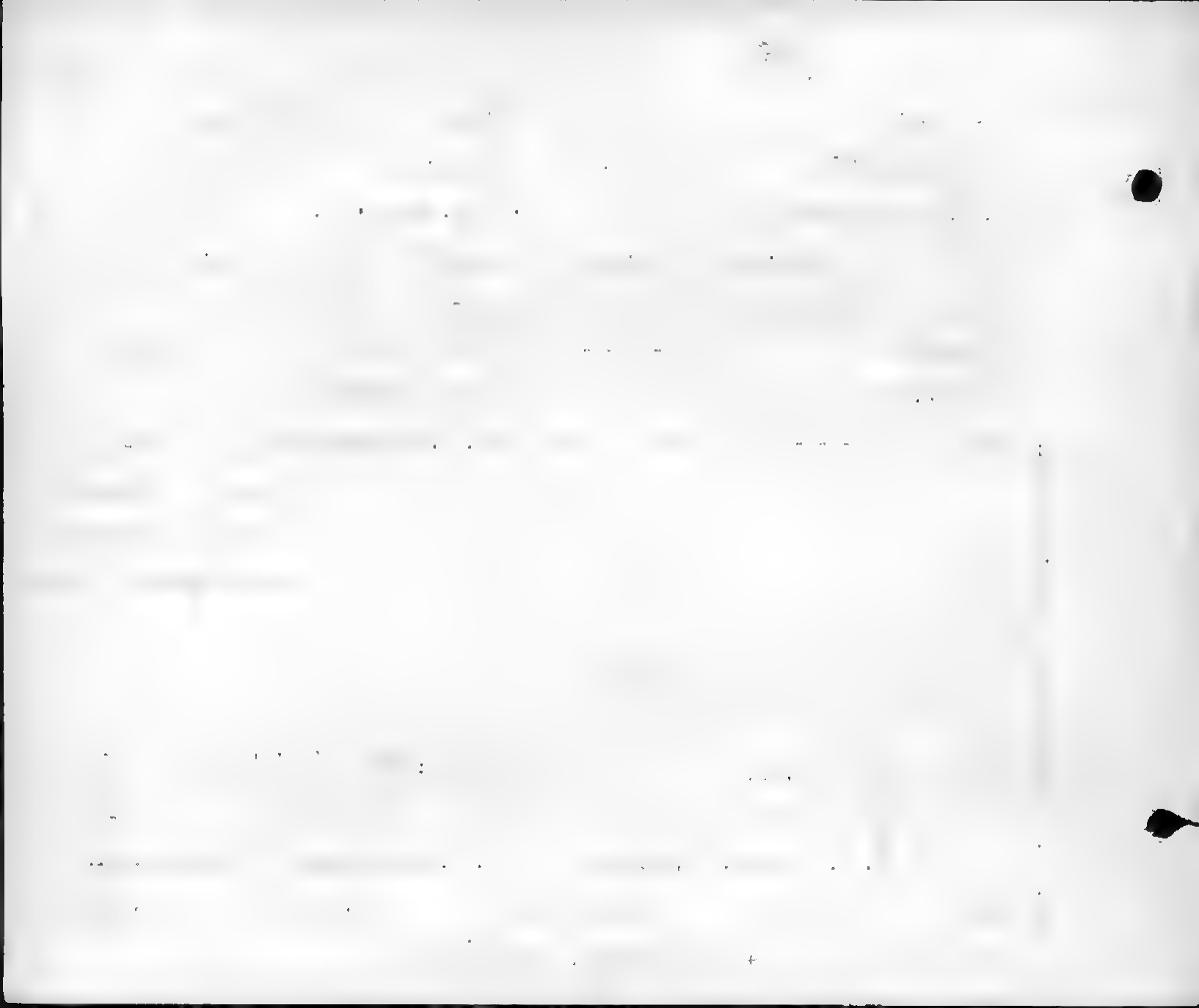
Mont. Co. Deputy Medical Examiner notified.

789

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66782

1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 116 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington				d. STREET ADDRESS 1727 N. Rhodes St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Florence Virginia COLLINS				4. DATE OF DEATH Month Day Year January 7 19 61				5. SEX Female				6. COLOR OR RACE Caucasian				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 4-22-81				9. AGE (in years last birthday) 79 yrs				10. IF UNDER 1 YEAR Months Days Hours Min.				11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) Mic higan				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John J. TONKIN				14. MOTHER'S MAIDEN NAME Virginia WEBSTER															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT (H) Robt. H. Collins, same as #2 above				Address																							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 421.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture Anterior chest wall heart lip DUE TO (c) with post-operative Staphylococcal Infection PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH 3 yrs 4 mos 3 9 mos																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)																															
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																							
21. I certify that (H) (this hospital) attended the deceased from Sept. 13 1960 to Jan. 7 1961 that (H) (we) last saw the deceased alive on Jan. 7 1961 and that death occurred at 1:15 PM from the causes and on the date stated above.																																			
22a. SIGNATURE L. V. WILLETT, LT, MC, USN				22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22c. PHYSICIAN'S NAME (Type)				22d. DATE SIGNED 1-7-61																							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-11-61				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) (State) Arlington Virginia																							
24. FUNERAL DIRECTOR'S SIGNATURE C. M. HANCOCK				25a. REC'D BY REGISTRAR Jan 10 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Hanks																											



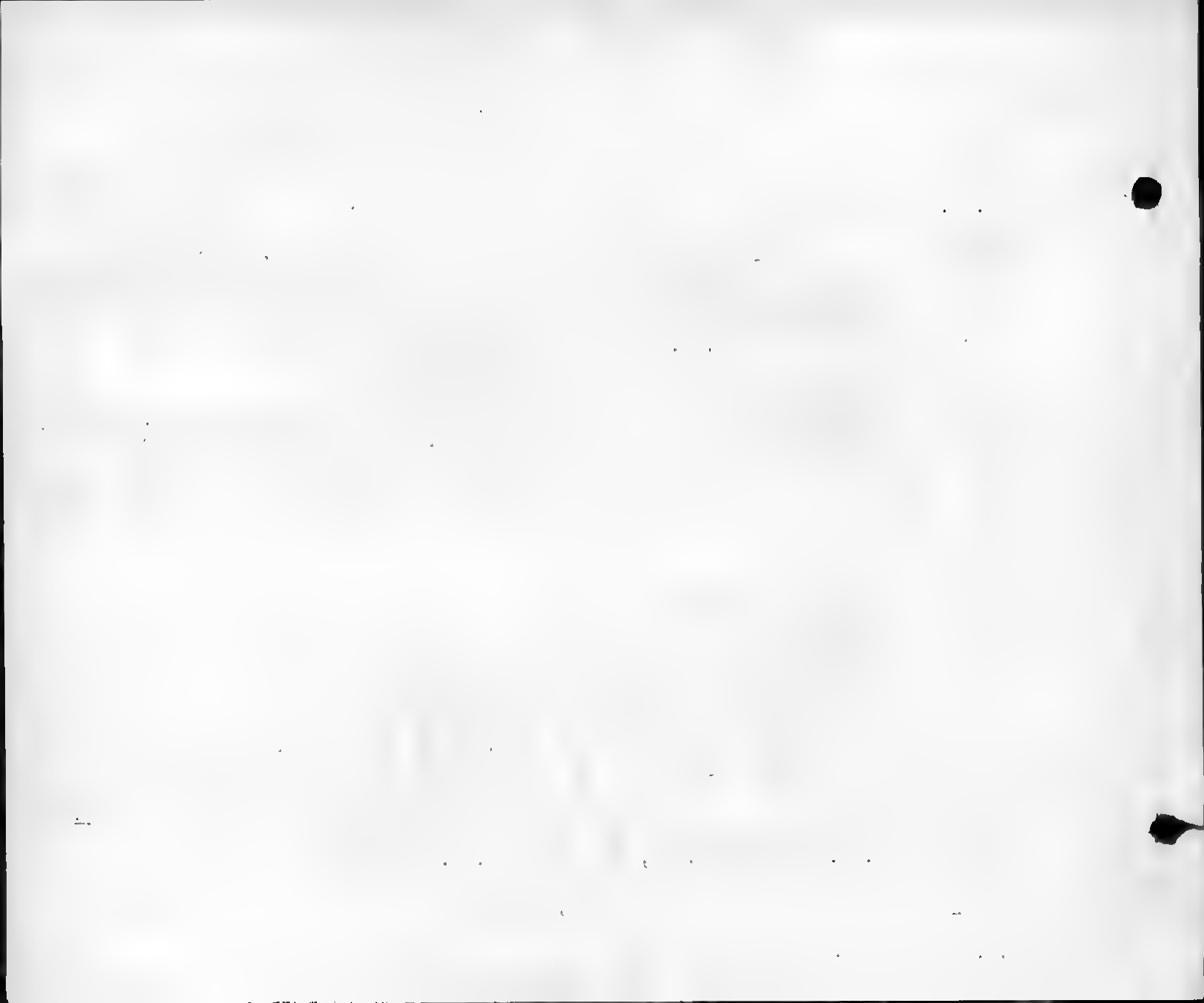
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790

CERTIFICATE OF DEATH

60783

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 64 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. STREET ADDRESS 7624 Sheryl Drive			
3. NAME OF DECEASED (Type or print) First Wilfred Middle James Last COLLINS				4. DATE OF DEATH Month January Day 31 Year 1961			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-28	
9. AGE (In years last birthday) 32 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. COLLINS				14. MOTHER'S MAIDEN NAME Levina SELLERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO 1946-1960		17. INFORMANT 1916 Kingston St., Norfolk, Va. (W) Mrs. Inez Collins, c/o Holzmilller	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 197.9 Reticulum Cell Sarcoma DUE TO (b) 197.9 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 197.9				INTERVAL BETWEEN ONSET AND DEATH 7 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 197.9							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 29 1960 to Jan. 31 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 31 1961 , and that death occurred at 10:15AM , from the causes and on the date stated above.							
22a. SIGNATURE P. G. Linaweaver, Lt, MC, USN				22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22c. DATE SIGNED 1-31-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 2-2-61		23b. DATE THEREOF 2-2-61		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Norfolk Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 1400 Chapin St. NW, WashDC				25a. REC'D BY REGISTRAR FEB 2 1961		25b. REGISTRAR'S SIGNATURE W. W. Chambers	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

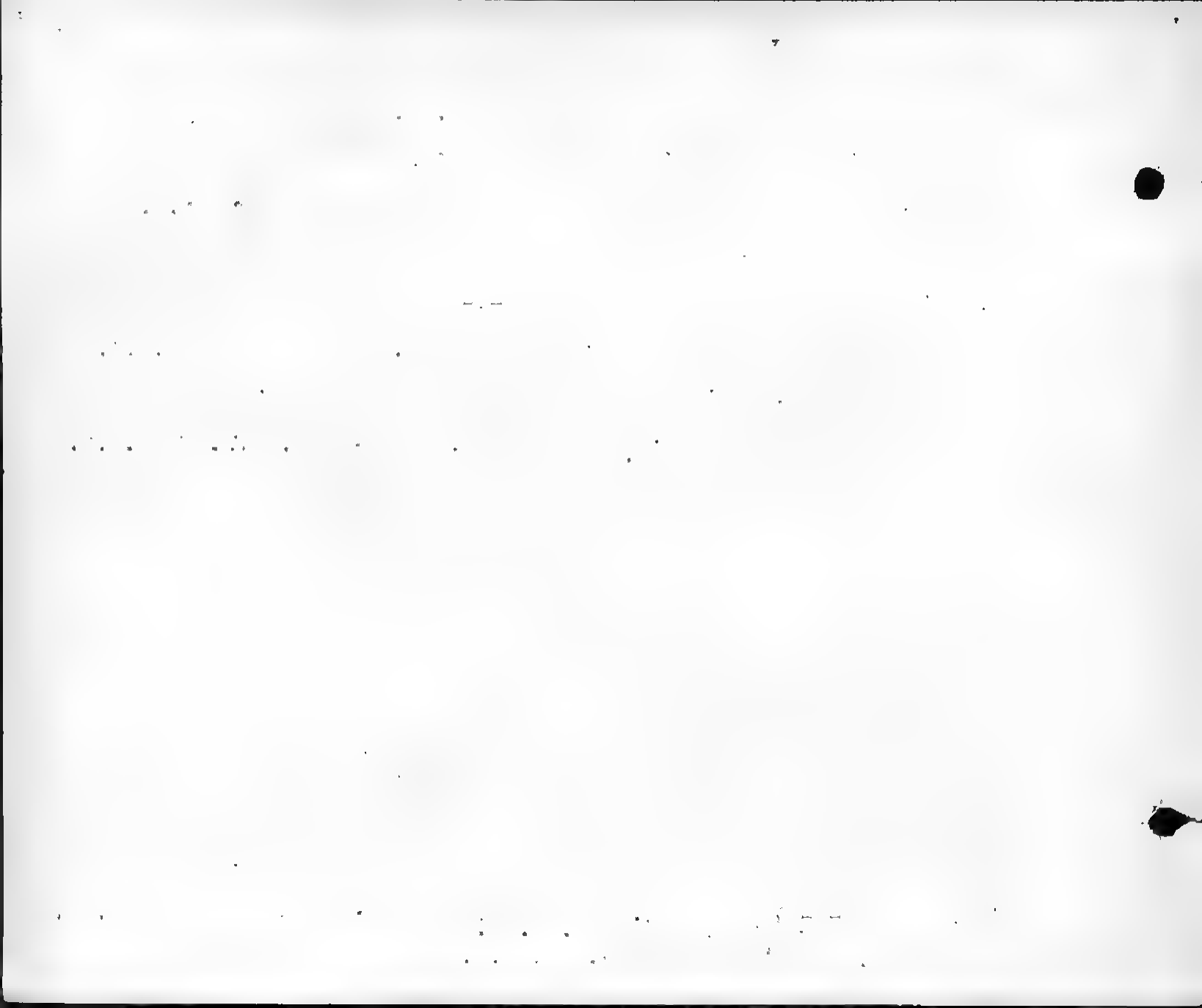
791

CERTIFICATE OF DEATH

Reg. Dist. No.

00784

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b 26 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL SANITORIUM		2. USUAL RESIDENCE (Where deceased lived. If institution: Res dence before admission) a. STATE D. C. b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 624 EVARTS STREET, N.E. e. AS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle ELIZABETH Last CORBLEY		4. DATE OF DEATH Month JAN Day 3 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-71
9. AGE (In years lost birthday) 89 yrs		10. IF UNDER 1 YEAR Months 8 Days 9	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY PENNA.	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL J. KELLY		14. MOTHER'S MAIDEN NAME MARGARET HACKETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT JOSEPH T. CORBLEY SR.		18. ADDRESS 3380 STUY VESTANT N.W. WASH. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO (b) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) SENILITY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month DEC Day 8 Year 1961	
20c. HOUR a. m. 1-3 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) WASHINGTON (County) D. C. (State)	
21. I certify that I attended the deceased from DEC 8 , 19 61 , to JAN 3 , 19 61 , that I last saw the deceased alive on 1-3 , 19 61 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis J. Collins M.D.		ADDRESS (Street, city or town, state) 5206 NORWICH DR	
PHYSICIAN'S NAME (Type) FRANCIS J. COLLINS		DATE SIGNED JAN 6 '61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-7-61	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		24a. REC'D BY REGISTRAR Francis J. Collins	
24b. REGISTRAR'S SIGNATURE Francis J. Collins		24c. DATE JAN 6 '61	



CERTIFICATE OF DEATH

Reg. Dist. No.

60785

792

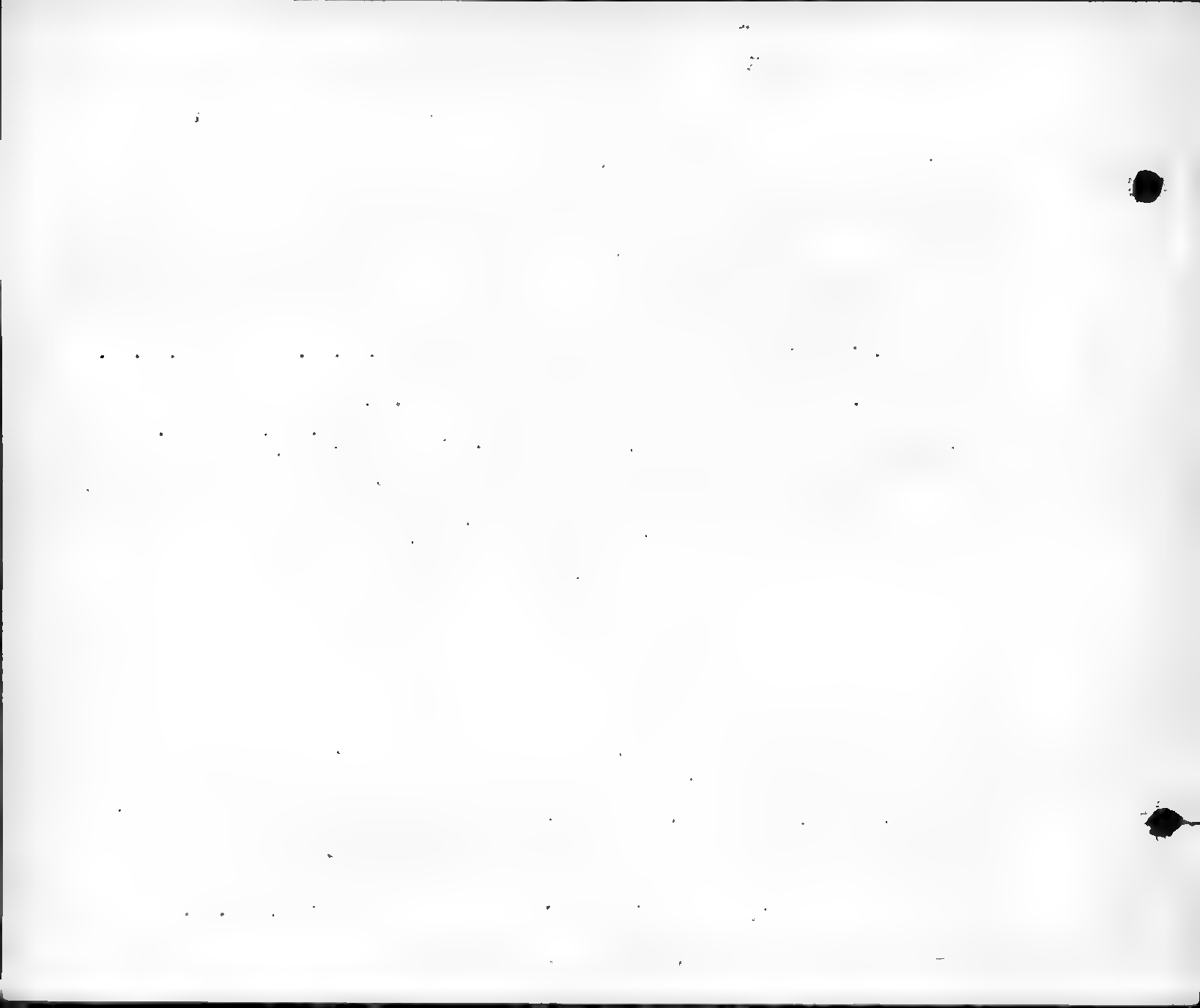
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut an Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u>		d. STREET ADDRESS <u>1342 South Columbus Street</u>	
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>Mc Daniel</u> Last <u>COX</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sgt. Washington Police Department</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James L. Cox</u>		14. MOTHER'S MAIDEN NAME <u>Martha G. Jamison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>XXXXXX</u>	
17. INFORMANT <u>Ralph S. Cox-</u>		Address <u>1342 S. Columbus St. Arlington, Virginia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 13</u> 19 <u>60</u> to <u>JAN. 20</u> 19 <u>61</u> , that I last saw the deceased alive on <u>JAN. 20</u> 19 <u>61</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Fowles</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>5206 N. Washington</u> <u>1/20/61</u>	
PHYSICIAN'S NAME (Type) <u>Cherry Chase, M.D.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/23/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Verly-Wheatley Funeral Home, Alexandria, Virginia</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

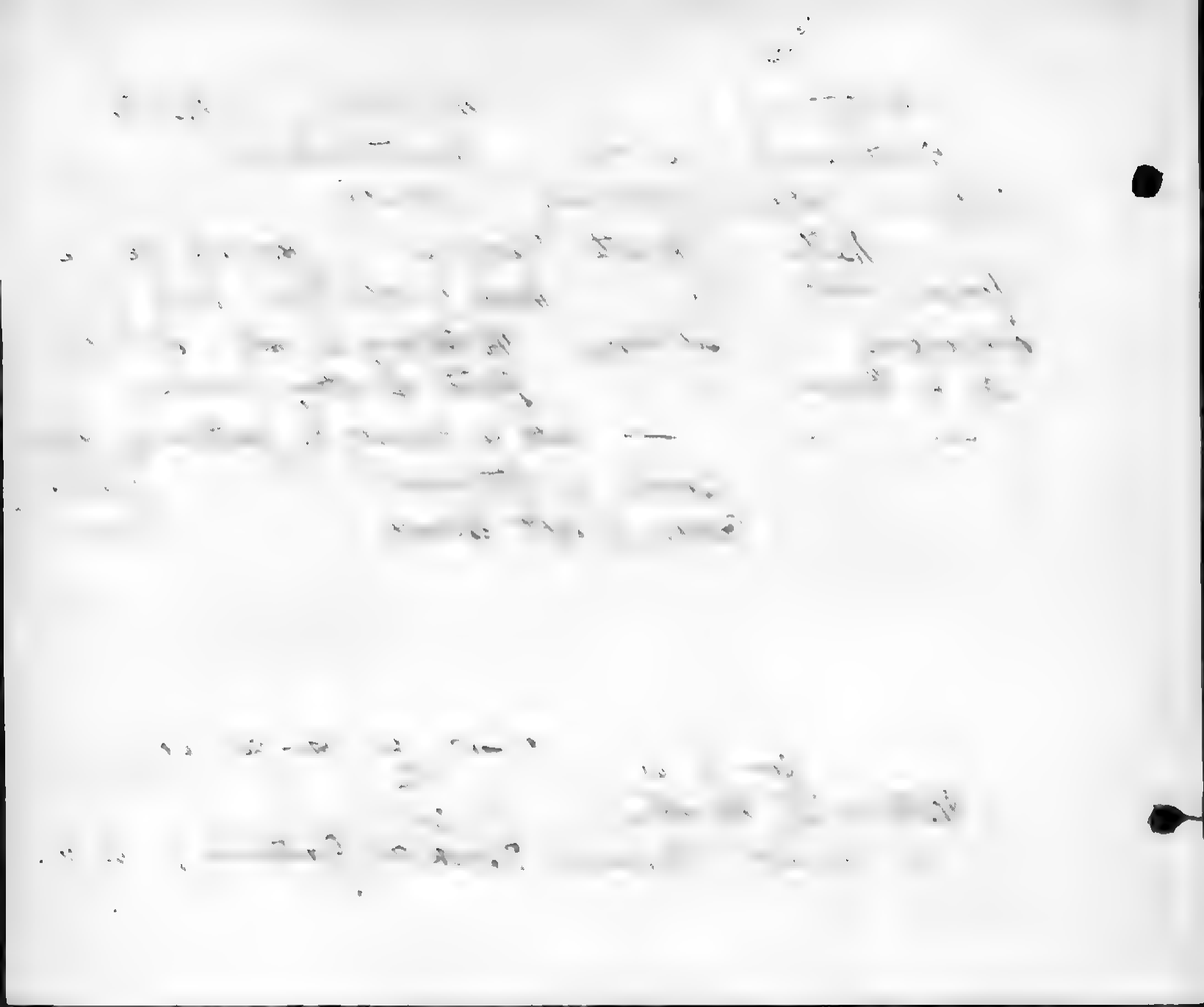
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

090

00786

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. LENGTH OF STAY IN 1b <u>6 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rockwood Rest Home, Gaithersburg</u>				e. STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or print) <u>Nettie</u> First <u>Genetta</u> Middle <u>Crawford</u> Last				4. DATE OF DEATH <u>January - 26 - 1961</u> Month <u>January</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March - 7 - 1870</u> 9. AGE (In years last birthday) <u>90</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>D. B. Croon</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Dorothy Croon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Ruth H. Brown, R1, Gaithersburg, Md</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u> <u>170X</u> DUE TO <u>Cancer of left breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u> <u>7 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7 - 19 - 1960</u> to <u>Jan - 26 - 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan - 12 - 1961</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>William C. Miller</u> M. D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>				22d. ADDRESS <u>7-Brookside, Gaithersburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-29-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Treasville</u>		23d. LOCATION (City, town or county) (State) <u>Germanstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Hartman, Gaithersburg, Md.</u> ADDRESS <u>—</u>				25a. REC'D BY REGISTRAR <u>—</u> DATE <u>JAN 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Haines</u>	



CERTIFICATE OF DEATH

00787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b Washington, D.C. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL SAN.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 3823 New Hampshire Ave NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LENA First Phillips Middle CRISWELL Last 4. DATE OF DEATH Month 1 Day 10 Year 1961		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9-9-1874 9. AGE (In years last birthday) 86 yrs. 10. UNDER 1 YEAR Months 3 Days 6 Hours 0 Min 0 11. UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY R.C. 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Kreyer, William 14. MOTHER'S MAIDEN NAME Mary Beckmann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO (If yes, give war or dates of service) ? 17. INFORMANT EB Phillips 29 Woodbridge Road Scarsdale, N.Y.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) GENERALIZED ARTERIO SCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 15, 1957 , to 1-10-1961 , that I last saw the deceased alive on 1-10-1961 , and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5206 Senechal Dr. DATE SIGNED ACTUAL SIGNATURE Henry M. Lowden M.D. PHYSICIAN'S NAME (Type) Henry M. Lowden Cherry Chase, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 1/13/61 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 22d. LOCATION (City, town, or county) (State) Suitland, Md.		23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C. 24b. REGISTRAR'S SIGNATURE JAN 16 '61 Arthur S. Hines	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTEND PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

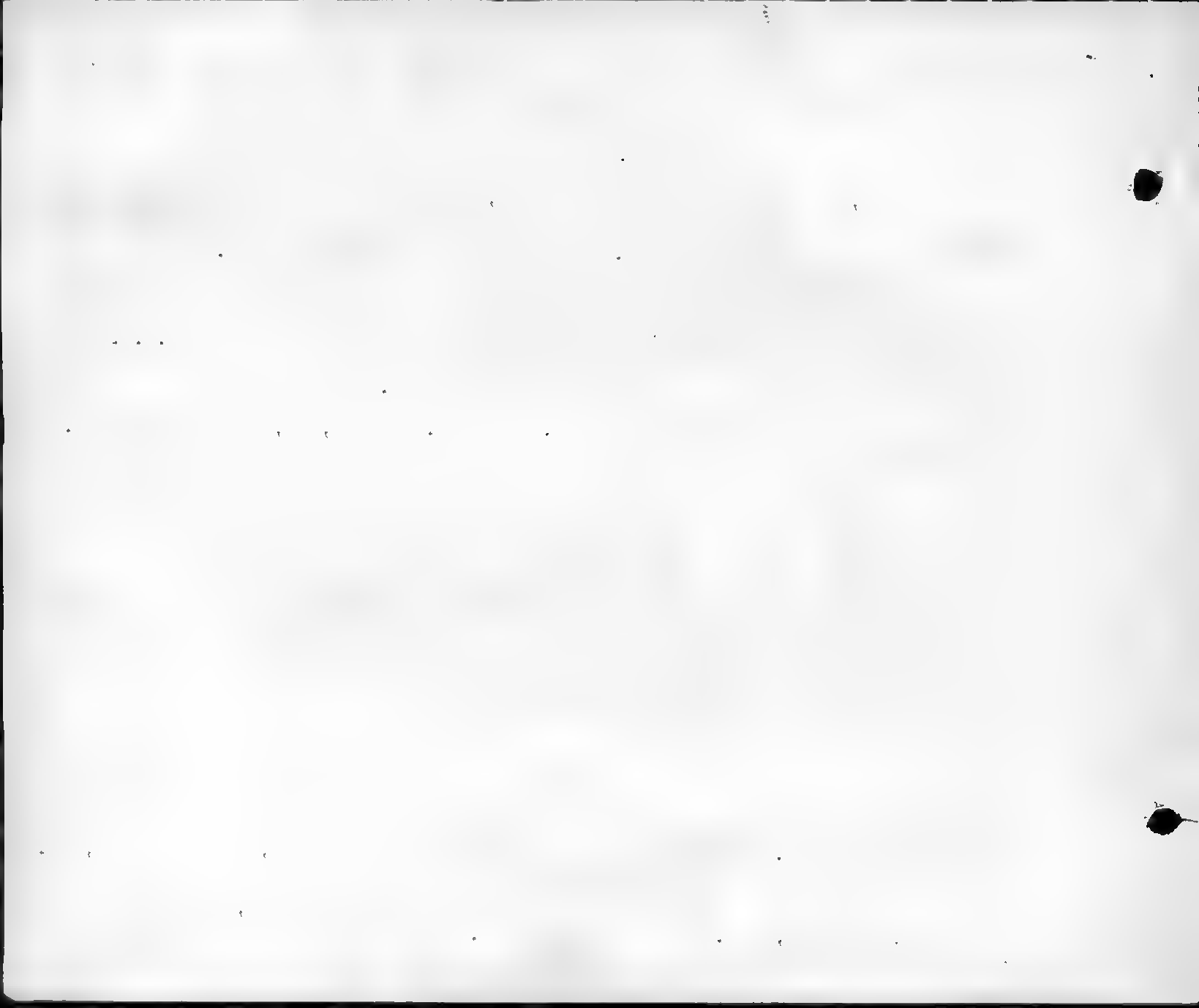
1

795

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60788

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b Since 1928			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,401 COLESVILLE ROAD				d. STREET ADDRESS 10,401 COLESVILLE ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BEATRICE Middle W. Last CROCKER				4. DATE OF DEATH Month JAN. Day 15 Year 19 61			
5 SEX FEMALE		6 COLOR OR RACE WHITE		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 1/17/02	
9. AGE (In years lost birthday) 58 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY Kensington Junior High School		11 BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benjamin Woodford				14. MOTHER'S MAIDEN NAME Lucretia B. Kinsman			
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO 226-42-6570		17 INFORMANT Mr. Arthur W. Crocker, 10,401 Colesville Rd. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma originating in the breast - severe anemia + congestive failure DUE TO (b) failure DUE TO (c) failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mos.							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Aug. 1, 1957, to 15 Jan. 1961, that (I) (we) last saw the deceased alive on 15 Jan. 1961, and that death occurred at 8 PM, from the causes and on the date stated above							
22a. SIGNATURE Ernest E. Harmon				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 1/15/61	
22c. PHYSICIAN'S NAME (Type) ERNEST E. HARMON				22d. ADDRESS 9301 Colesville Road, Silver Spring, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 1/18/61		23c NAME OF CEMETERY OR CREMATORY Lewinsville Presbyterian Church Yard		23d LOCATION (City, town, or county) (State) Lewinsville, Virginia	
24 FUNERAL DIRECTOR'S SIGNATURE Warner E. Pomfrey, Inc. Myrna L. Gaska				25a REC'D BY REGISTRAR DATE JAN 25 '61		25b REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

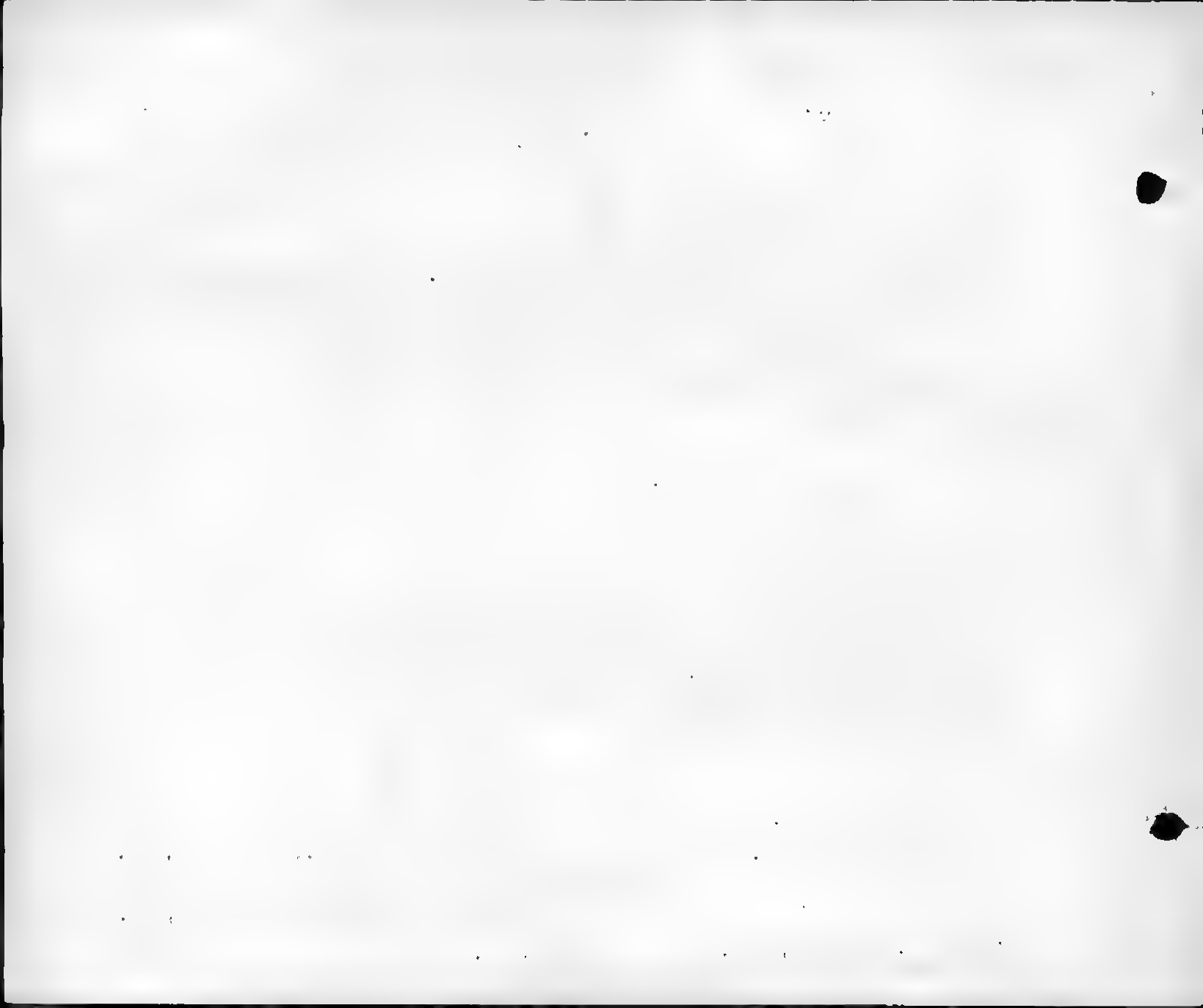
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

796

00780

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
f. STREET ADDRESS <u>12810 Turkey Branch</u>				RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BABY Girl Dalesandro</u>				4. DATE OF DEATH <u>January 24 1961</u>			
5. SEX <u>Fem</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/23/61</u>	
9. AGE (In years last birthday) <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS Hours <u>1</u> Min <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Mr. Joseph Dalesandro</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Dorene Lasher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Depression Respiratory Center</u> <u>752X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hydrocephally, congenital</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/23/61</u> to <u>1/24/61</u> that (I) <u>twice</u> last saw the deceased alive on <u>1/24/61</u> 19 <u>61</u> , and that death occurred on <u>1/24/61</u> at <u>—</u> PM, from the causes and on the date stated above							
22a. SIGNATURE <u>Richard M. Auld</u>				22b. DATE SIGNED <u>1/24/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD M. AULD</u>				22d. ADDRESS <u>809 Viers Mill Rd., Rockville, Md.</u>			
23a. BURIAL, CREMATON REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATT OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Dumortier</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>JAN 27 1961</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles E. Frank</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

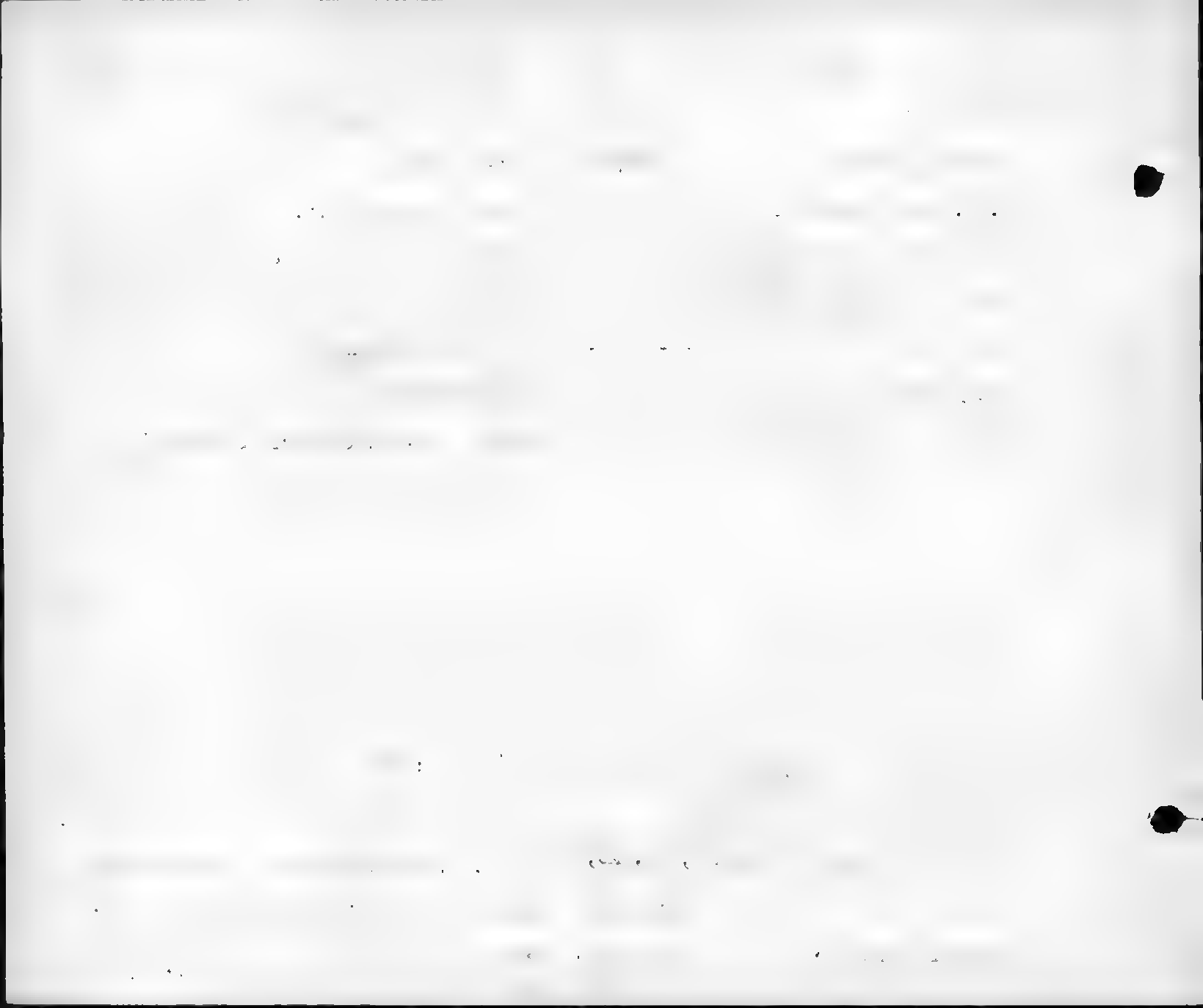
CERTIFICATE OF DEATH

797

Sec. 23 Film 6278 1-10-61 et

60790

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1363 F Street, N.E. d. STREET ADDRESS 1363 F Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lealer DANCY				4. DATE OF DEATH Month Day Year January 2 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-2-03	
9. AGE (In years last birthday) 57 yrs.		10. AGE (In years last birthday) 57 yrs.		11. IF UNDER 1 YEAR Months Days Hours Min 57		12. IF UNDER 24 HRS Months Days Hours Min 57	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY North Carolina		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Jolly DRAKE				14. MOTHER'S MAIDEN NAME Cindy LYONS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. (D) Mrs. Lossie B. Gilbert, same as #2			
17. INFORMANT (D) Mrs. Lossie B. Gilbert, same as #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolization DUE TO (b) Thrombophlebitis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 464X				INTERVAL BETWEEN ONSET AND DEATH 24 hours			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from Dec. 24 1960 to Jan. 2 1961 , that (X) (we) last saw the deceased alive on Jan. 2 1961 , and that death occurred at 2:30 PM from the causes and on the date stated above.							
22a. SIGNATURE William P. Baker				22b. DATE SIGNED 1-3-61			
22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Tran. C. B. Kelly				23b. DATE THEREOF Jan. 3 1961			
23c. NAME OF CEMETERY OR CREMATORY National Harmony Cemetery				23d. LOCATION (City, town, or county) (State) Prince George Co. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Spangler Funeral Home, 524 8th St. NE, WashDC				25a. REC'D BY REGISTRAR DATE JAN 6 '61			
				25b. REGISTRAR'S SIGNATURE Arthur S. Kram			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

158
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00291

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11608 Rockville Pike</u>		d. STREET ADDRESS <u>11608 Rockville Pike</u>	
3. NAME OF DECEASED (Type or print) <u>George T. Darnie</u>		4. DATE OF DEATH <u>Jan 8 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>La</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. Darnie</u>		14. MOTHER'S MAIDEN NAME <u>Maime Cronson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Bessie Darnie - Sister</u>		Address <u>Stun 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Boschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Boschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/10/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JAN 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



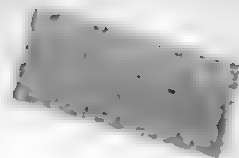
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

799

6079

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				c. LENGTH OF STAY IN 1b <i>6 DAYS</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens Sanitarium</i>				d. STREET ADDRESS <i>13404 Nimitz Rd.,</i>			
3. NAME OF DECEASED (Type or print) <i>Frank A DeFries</i>				4. DATE OF DEATH Month <i>1</i> Day <i>1</i> Year <i>1961</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8 Mar. 1879</i>		9. AGE (In years last birthday) <i>81</i> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>		11. BIRTHPLACE (State or foreign country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>August H. DeFries</i>				14. MOTHER'S MAIDEN NAME <i>Mary Bish</i>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT <i>Daughter</i>		Address <i>Mrs. Marion D. Hall Same as item #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1) Renal failure (Nephrosclerosis)</i> <i>446X</i> DUE TO (b) <i>2) Congestive cardiac failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>1</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i> <i>7 yrs.</i>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prostatectomy, 1954 (hyperthrophy, benign)</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 31, 1960</i> to <i>Jan. 1, 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec. 31, 1960</i> , and that death occurred at <i>3:55 PM</i> , from the causes and on the date stated above							
22a. SIGNATURE <i>Philip H. Varner,</i>				22b. DATE SIGNED <i>1/1/61</i>		22c. PHYSICIAN'S NAME (Type) <i>PHILIP H. VARNER</i>	
22d. ADDRESS <i>10,620 Ha. Ave., Wheaton, Md.</i>							
23a. BURIAL, CREMAT., OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 3, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>ROBERT A. PUMPHERY Bethesda, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>JAN 3 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

I



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

800

CERTIFICATE OF DEATH

00793

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u> c. LENGTH OF STAY IN 1b <u>2000 days</u> d. NAME OF HOSPITAL OR INST. T.U. (if not in hospital, give street address) <u>Washington Anni-torium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>804 Philadelphia</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Victor</u> First Middle Last		4. DATE OF DEATH <u>January 25</u> 19 <u>61</u> Day Month Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-13-11</u>	
9. AGE (In years last birthday) <u>49</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineering (Electric)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Engineering Aide</u> 11. BIRTHPLACE (County & State, or foreign country) <u>PA</u> 12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Victor Dersath</u>		14. MOTHER'S MAIDEN NAME <u>Laura Meyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>none</u>		16. SOCIAL SECURITY NO <u>171-01-6401</u> 17. INFORMANT <u>Pls. Chart - Washington Anni-torium & Hospital</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> (b) <u>Intracerebral haemorrhage</u> (c) <u>Ruptured intracranial aneurysm</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u> </u> (b) <u> </u> (c) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 27, 1960</u> to <u>JAN 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>JAN 25, 1961</u> , and that death occurred at <u>1030A</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>John T. Lord</u>		22b. DATE SIGNED <u>1/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John T. Lord</u>		22d. ADDRESS <u>1015 Spring St. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CONYNGHAM CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>CONYNGHAM, LUZERNE COUNTY, PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Ziska</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 31 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. REGISTRAR'S NAME <u>Arthur S. Kraus</u>	

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A18 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

801

60784

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>			
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>Rockington (Cardiac Sanatorium)</u>				d. STREET ADDRESS <u>12,113 HUNTERS LANE</u>			
3. NAME OF DECEASED (Type or print) <u> Eunice </u> First <u> Jenkins </u> Middle <u> </u> Last <u> </u>				4. DATE OF DEATH Month <u> 1 </u> Day <u> 19 </u> Year <u> 1961 </u>			
5. SEX <u> F </u>	6. COLOR OR RACE <u> white </u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u> 12 March 1901 </u>	9. AGE (In years last birthday) <u> 60 </u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> House Mother </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> College Fraternity </u>		11. BIRTHPLACE (State or foreign country) <u> Indiana </u>		12. CITIZEN OF WHAT COUNTRY? <u> USA </u>	
13. FATHER'S NAME <u> Arthur Jenkins </u>				14. MOTHER'S MAIDEN NAME <u> Frances Campbell </u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u> no </u>		16. SOCIAL SECURITY NO. <u> yes </u>		17. INFORMANT Address <u> Mr. Edward F. Devol, Jr., 12,113 Hunters Lane </u> <u> Rockville, Md. </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u> Adenocarcinoma of Uterus </u> <u> 174-X </u> DUE TO <u> with local metastases </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> 10 mos </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> 19 </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u> 4/3/45 </u> to <u> 1/13/1961 </u> that (I) <u> saw </u> last saw the deceased alive on <u> 1/13/1961 </u> and that death occurred at <u> A.M. </u> from the causes and on the date stated above							
22a. SIGNATURE <u> Russell B. Arnold M.D. </u>				22b. ADDRESS <u> 8801 Coleville Road, Silver Spring, Md. </u>			
22c. PHYSICIAN'S NAME (Type) <u> Russell B. Arnold M.D. </u>				22d. ADDRESS <u> 8801 Coleville Road, Silver Spring, Md. </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City town or county) (State)	
<u> TRANS. & BURIAL </u>		<u> 1/21/61 </u>		<u> FAIRVIEW CEMETERY </u>		<u> New Albany, Indiana </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u> Raymond E. Pumphrey, Inc. </u>				25a. REC'D BY REGISTRAR DATE <u> JAN 25 '61 </u>			
ADDRESS <u> SILVER SPRING, MD. </u>				25b. REGISTRAR'S SIGNATURE <u> Charles E. Hines </u>			

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

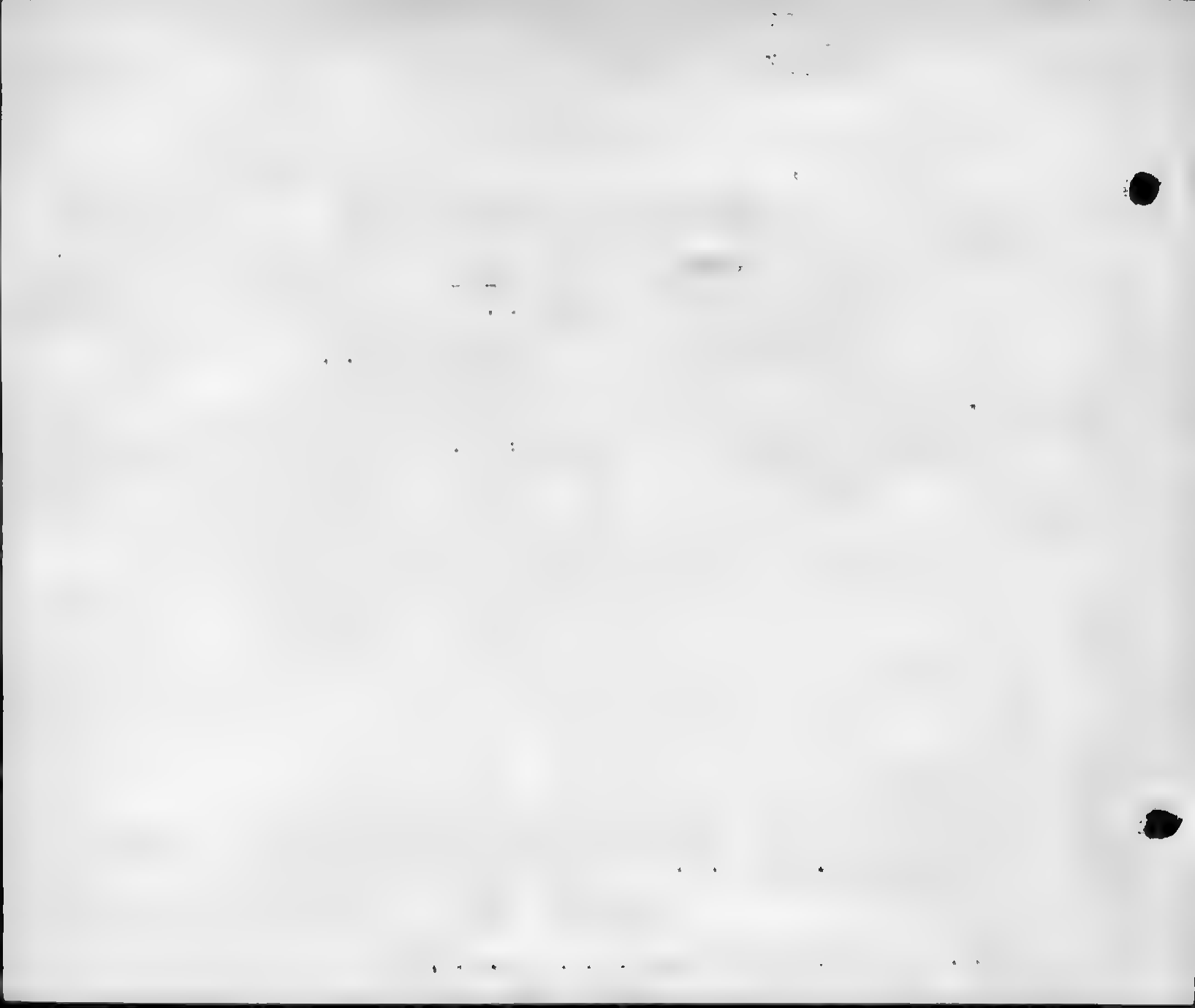
1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

802 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60795

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant 16		d. STREET ADDRESS 113 68th Place,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Armando Joseph Di Gennaro		4. DATE OF DEATH January 19 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12-16-25		9. AGE (In years last birthday) 35 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder: Silver Spring Iron Works		10b. KIND OF BUSINESS OR INDUSTRY D.C.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Mr. Nicola Di Gennaro		14. MOTHER'S MAIDEN NAME Rosa Palladini		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW 2 Army		16. SOCIAL SECURITY NO.		17. INFORMANT Wife: Mrs. Elvira Di Gennaro, same as above		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 916.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Toxemia Extensive Body Burns		INTERVAL BETWEEN ONSET AND DEATH 48 hr. 4 days 9 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Welding - cleaning flint exploded. Burning over 1/2 body		20c. TIME OF INJURY Month, Day, Year 1120 a.m. 1/10 1961		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory		20f. (City or town) Silver Spring		(County) Montgomery		(State) M.D.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-61		22c. NAME OF CEMETERY OR CREMATORY Arlington Hall		22d. LOCATION (City, town, or country) Springer, Va		22e. (State) VA		23. FUNERAL DIRECTOR R.A. Mattingly		ADDRESS 137 14th Street, S.E. Wash. D.C.		24a. REC'D BY REGISTRAR Jan 23 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thane		DATE SIGNED 1-20-1961			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1.
803

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY

3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING

4. LENGTH OF STAY IN 1b 19 1/2 yrs.

5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING

6. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 314 BREWSTER COURT

7. STREET ADDRESS 314 BREWSTER COURT

8. IS RESIDENCE ON A FARM? YES ☐ NO ☒

9. NAME OF DECEASED (Type or print) First Middle Last DAVID ELLSWORTH DIXON

10. DATE OF DEATH Month Day Year Jan 18 1961

11. SEX MALE

12. COLOR OR RACE WHITE

13. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

14. DATE OF BIRTH 4/19/94

15. AGE (In years last birthday) 66 yrs

16. IF UNDER 1 YEAR Months Days

17. IF UNDER 24 HRS Hours Min

18a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architectural Engineer (retired)

18b. KIND OF BUSINESS OR INDUSTRY Public Health Dept. U. S. Gov't.

19. BIRTHPLACE (State or foreign country) MARYLAND

20. CITIZEN OF WHAT COUNTRY? U.S.A.

21. FATHER'S NAME JAMES B. DIXON

22. MOTHER'S MAIDEN NAME ~~KATHERINE HONING~~ KATHERINE HONING

23. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no

24. SOCIAL SECURITY NO 578-52-2765

25. INFORMANT Address Mrs. May M. Dixon, 314 Brewster Court

26. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 421-1 Coronary Thrombosis
DUE TO (b) generalized arteriosclerosis
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH 4 days 12 yrs

27a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

27b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

27c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19

27d. INJURY OCCURRED While at work ☐ Not while at work ☐

27e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

27f. (City or town) (County) (State)

28. I certify that (I) (this hospital) attended the deceased from 2-17-1948 to 1-18-1961, that (I) (we) last saw the deceased alive on 1-18-1961, and that death occurred at 9 PM, from the causes and on the date stated above.

29a. SIGNATURE Chas. W. Harnsberger M.D.

29b. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ 1-19-61 SIGNED

29c. PHYSICIAN'S NAME (Type) CHAS. W. HARNESBERGER

29d. ADDRESS 4201 NEW HAMPSHIRE AVE NW

30a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

30b. DATE THEREOF 1/21/61

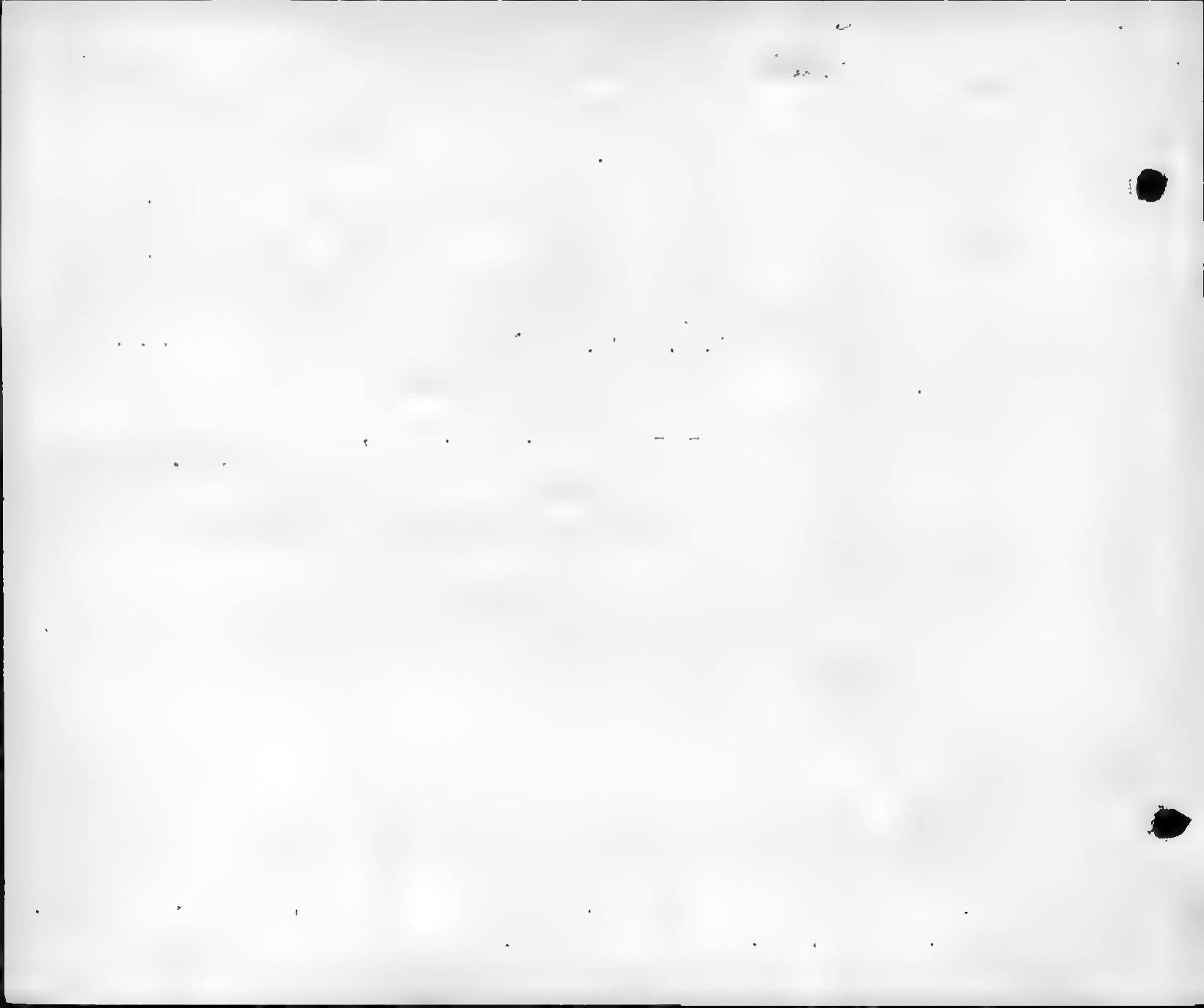
30c. NAME OF CEMETERY OR CREMATORY BATES MEM. CEMETERY

30d. LOCATION (City, town, or county) (State) SNOW HILL, WORCESTER COUNTY, MD.

31. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Giska ADDRESS SILVER SPRING, MD.

32a. REC'D BY REGISTRAR DATE JAN 25 '61

32b. REGISTRAR'S SIGNATURE Arthur L. Hume



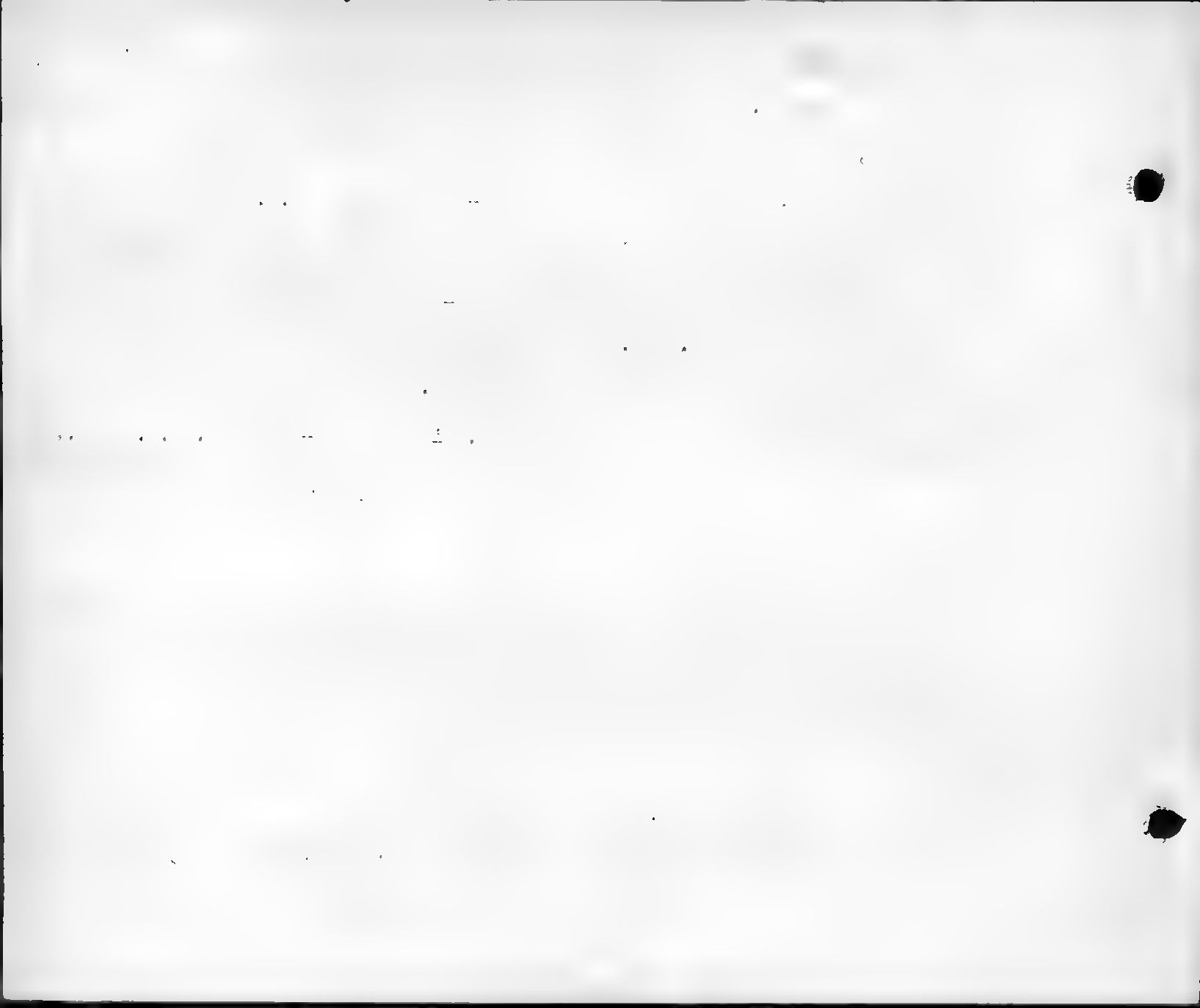
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

804

00797

1. PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE DC b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Maryland				c. LENGTH OF STAY IN 1b 1-week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Haven Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC			
d. STREET ADDRESS 1908- 17th Street S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
ANNIE		M		DOERING			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13- 1885	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.		10. DATE OF DEATH Jan 9 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY US. Gov.		11. BIRTHPLACE (State or foreign country) Washington, DC	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jonas Doering				14. MOTHER'S MAIDEN NAME Helen V. Wagner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT Helen V. Gibson Address 1908- 17th St. S.E. Wash., DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro Vascular Necromatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis (c) (d) 48 hrs INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from 1933 to 1/9 , 19 61 , that (I) (we) lost the deceased alive on 1/8 , 19 61 , and that death occurred at 12:10 A.M. from the causes and on the date stated above							
22a. SIGNATURE R.C. Kirchner				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) R.C. KIRCHNER	
22d. ADDRESS 10480 N.H. Dr - Takoma Park Md				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Jan 11-61		23c. NAME OF CEMETERY OR CREMATORY Washington National Switland, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Sinmon Bros 1661-9d Hope Rd S E				25a. REC'D BY REGISTRAR DATE JAN 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

805

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 21 Film 0279 1-25-61 et

00798

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New Hersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark	
c. LENGTH OF STAY IN 1b 9 Days		d. STREET ADDRESS 200 Weequahic Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle (None) Last Dolgan		4. DATE OF DEATH Month January Day 19, Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH May 1, 1911	9. AGE (In years last birthday) 49 yrs
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Technologist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Issac Dolgan		14. MOTHER'S MAIDEN NAME Gussie Mendelsohn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcus Septicemia DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dermatomyositis DUE TO (c) Carcinoma of the Breast		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 10, 1961 to January 12, 1961 that (I) (we) last saw the deceased alive on January 19, 1961 , and that death occurred at 9:05 AM , from the causes and on the date stated above			
22a. SIGNATURE Daniel B. Drachman M.D.		22b. DATE SIGNED 1/19/61	
22c. PHYSICIAN'S NAME (Type) Daniel B. Drachman, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 22, 1961	
23c. NAME OF CEMETERY OR CREMATORY HEBREW CEMETERY		23d. LOCATION (City, town, or county) (State) NEWARK N. J.	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Dargatzis & Sons		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS 3501-14 ST. N.W.		DATE JAN 23 '61	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

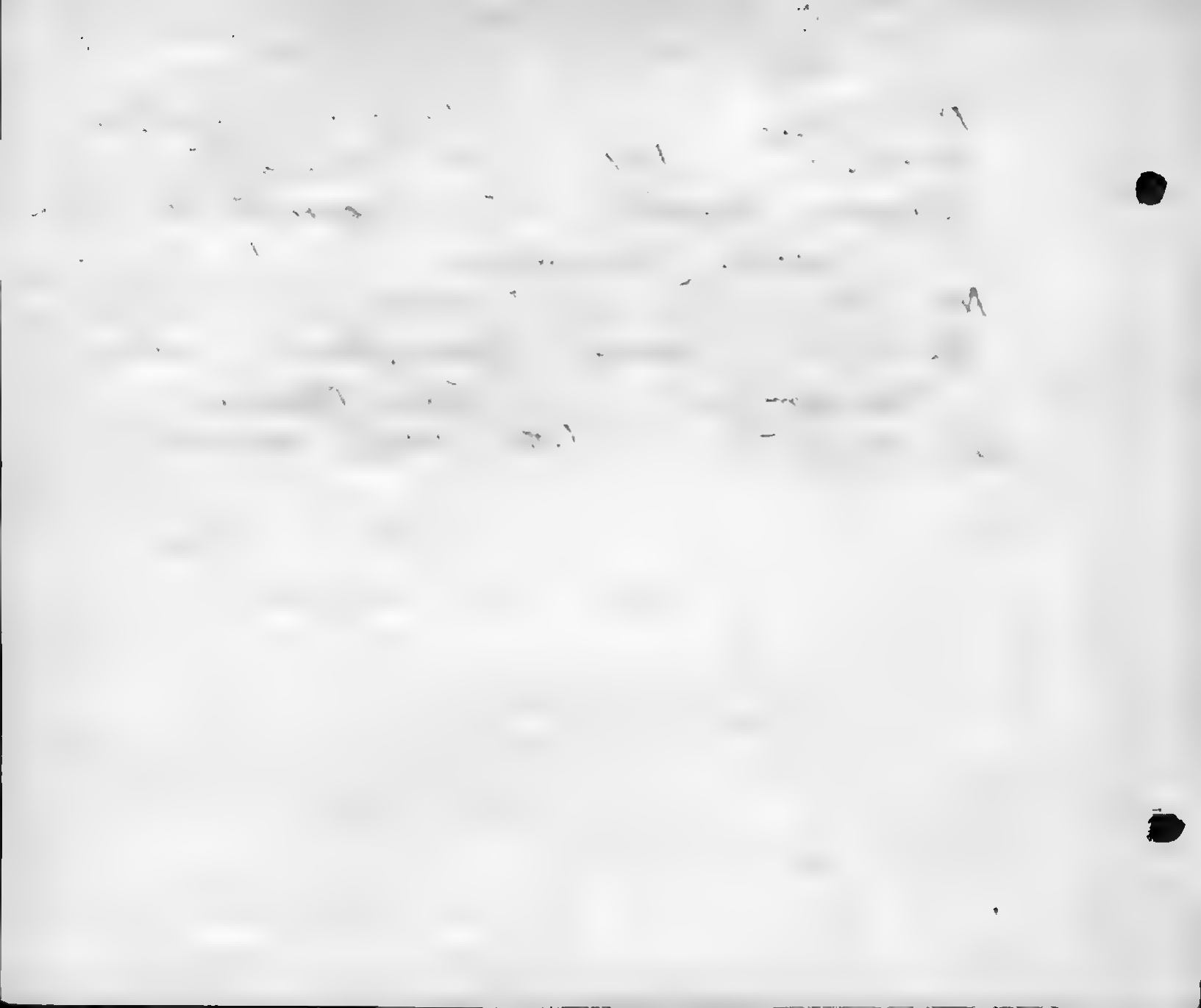
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

806

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60799

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Heights</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5104 Wapahanna Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rudolph</u> Middle <u>John</u> Last <u>Domini</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housing</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Domini</u>		14. MOTHER'S MAIDEN NAME <u>Julia Mendini</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>111-05-7199</u>	
17. INFORMANT <u>Catherine M. (wife)</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 23 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR <u>H. Don. DeVal</u>		24a. REC'D BY REGISTRAR <u>Wash. DC</u>	
24b. REGISTRAR'S SIGNATURE <u>2224-Wis Ave</u>		DATE <u>JAN 23 '61</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

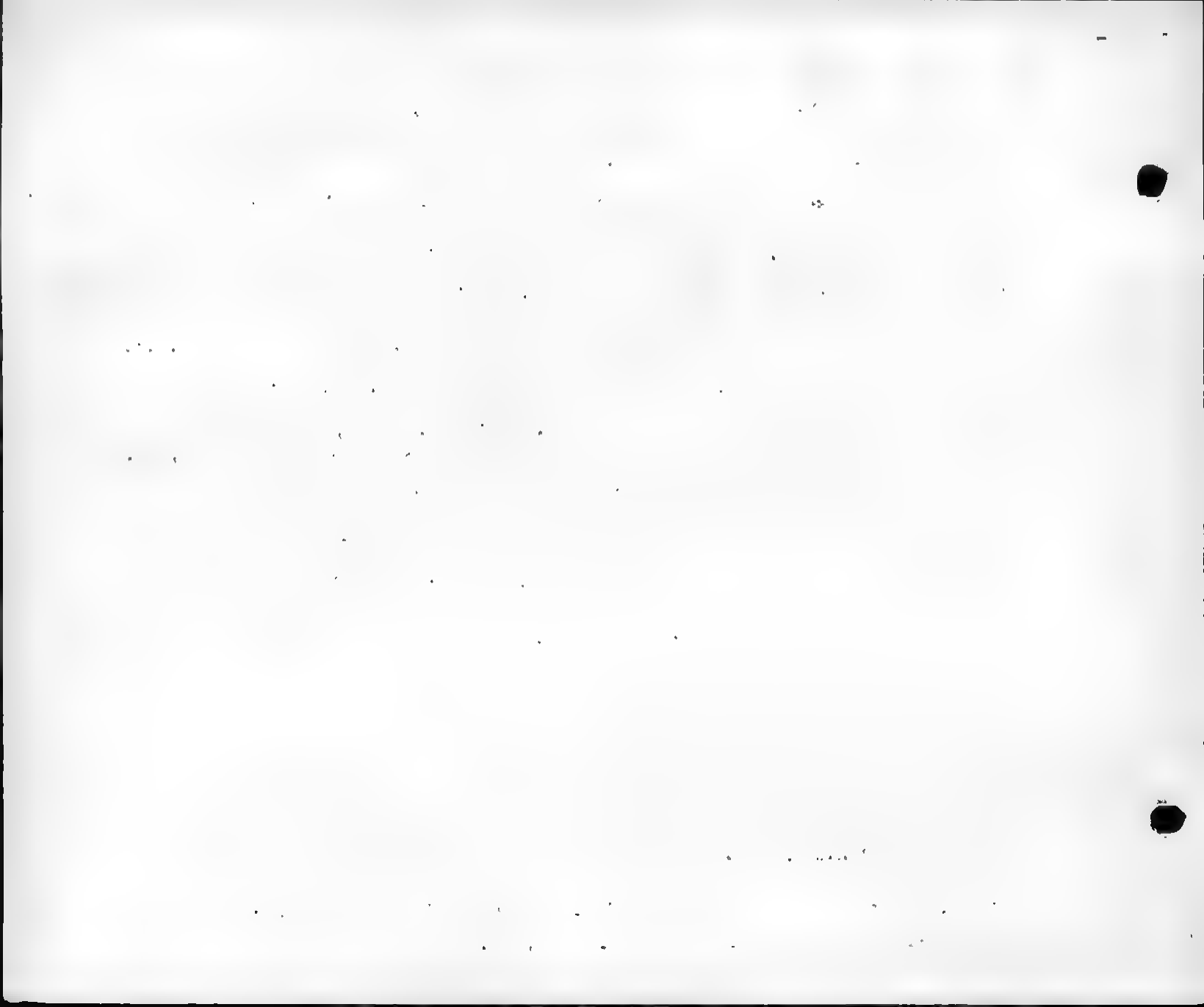
00800

307

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b 2 yr s. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL NURSING HOME		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 1 313 QUAINT ACRES DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle LOUETTA Last DONLEY		4. DATE OF DEATH Month 1 Day 31 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/77
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Goshen, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Christopher Wellner		14. MOTHER'S MAIDEN NAME Matilda Jane Doughman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Walter A. Smith, 313 Quaint Acres Drive Silver Spring, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ESSENTIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 16, 1959 to 1-31, 1961 that I last saw the deceased alive on 1-31, 1961 and that death occurred at 6 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5306 Norway Dr. Chevy Chase, Md. DATE SIGNED			
ACTUAL SIGNATURE Henry M. Lowden M.D.		PHYSICIAN'S NAME (Type) HENRY M. LOWDEN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/61	
22c. NAME OF CEMETERY OR CREMATORY DAYTON MEM. PARK CEMETERY		22d. LOCATION (City, town, or county) (State) DAYTON, OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc. ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR FEB 6 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Kenna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



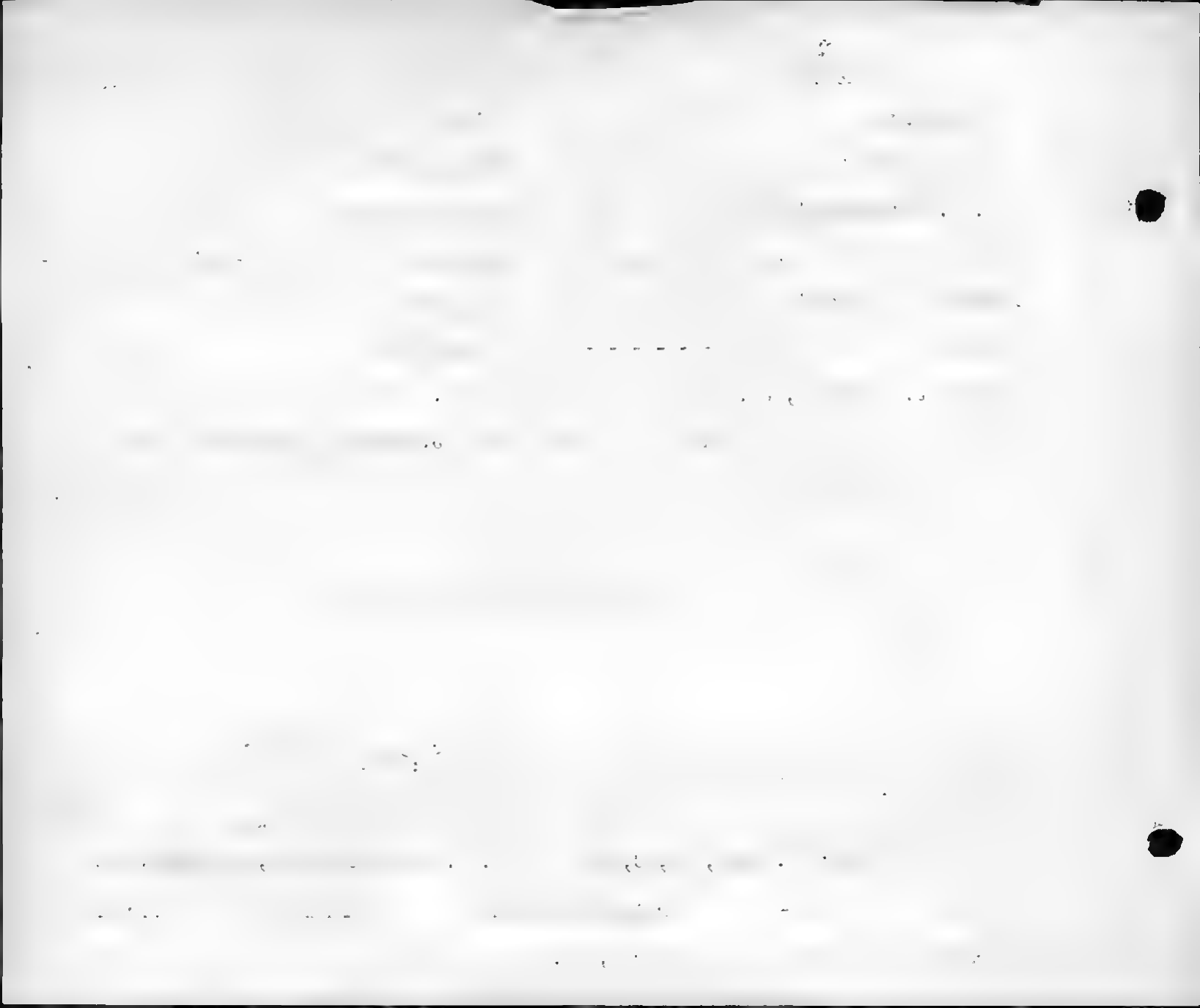
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60861

308

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institut on. Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church			
f. STREET ADDRESS 734 Kadola Place				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jo Middle Anne Last DONNELLY				4. DATE OF DEATH Month January Day 5 Year 19 61			
5 SEX Female		6 COLOR OR RACE Caucasian		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 12-23-49	
9 AGE (In years last birthday) 11 yrs		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min 11		IF UNDER 24 HRS Hours 11 Min 11			
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11 BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13 FATHER'S NAME Daniel J. DONNELLY, JR.				14. MOTHER'S MAIDEN NAME Eva J. JETER			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None		17 INFORMANT (F) Daniel J. Donnelly, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia INTERVAL BETWEEN ONSET AND DEATH 2 days							
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia DUE TO							
(c) acute lymphocytic leukemia DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County, (State)							
21 I certify that (X) (this hospital) attended the deceased from December 19 60 to January 5 19 61 that (X) (we) last saw the deceased alive on January 5 19 61 and that death occurred at 2:28 AM from the causes and on the date stated above.							
22a. SIGNATURE Robert V. Rack				22b. DATE SIGNED 1-5-61		22c. PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-10-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24 FUNERAL DIRECTOR'S SIGNATURE Pearsons Funeral Home, Falls Church, Va.				25a. REC'D BY REGISTRAR JAN 10 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Kenna	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



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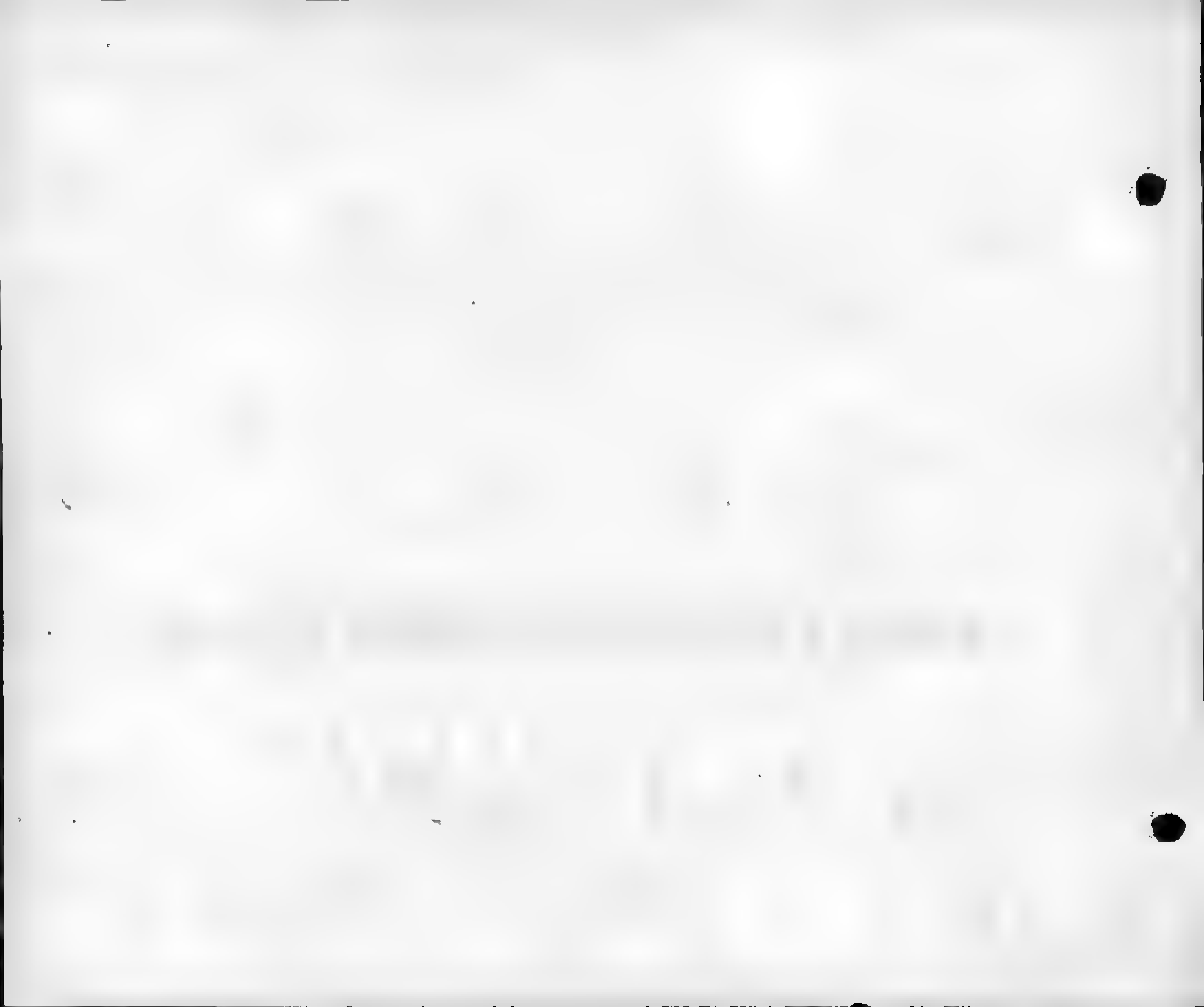
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
809									
Item 6-111-1001 2-20-61									
16842									
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital					d. STREET ADDRESS 100 North Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Frank Middle David Last Dorsey					4. DATE OF DEATH Month January Day 2 Year 1961				
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1884 Oct. 28, 1884		9. AGE (In years last birthday) 76 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad Repair		11. BIRTHPLACE (State or foreign country) Poolesville, M. d.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME William Dorsey					14. MOTHER'S MAIDEN NAME Unknown Anna Hamilton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					16. SOCIAL SECURITY NO		17. INFORMANT Harold S. Dorsey Address 100 North Street		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4-93X IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subtotal Gashed my for Carcinoma Stomach; Int. Obstruction 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Dec 17, 1960 to Jan 2, 1961 , that (I) (we) last saw the deceased alive on Jan 2, 1961 , and that death occurred at 11:15 PM , from the causes and on the date stated above									
22a. SIGNATURE John P. Habulin					22b. DATE SIGNED 1-3-61				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS 1015 Spring St. Silver Spring, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-8-61		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park		23d. LOCATION (City, town, or county) (State) Rockville, Md			
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Arthur L. Kline		
					DATE JAN 9 '61				



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de- necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00803

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selma Spring</u> c. LENGTH OF STAY IN 1b <u>13 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10216 Capital View Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selma Spring</u> d. STREET ADDRESS <u>10216 Capital View Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Anthony Dore</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		4. DATE OF DEATH <u>Jan 26 1961</u> 9. AGE (in years) IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min <u>38</u> yrs <u>5</u> months <u>5</u> days <u></u> hours <u></u> min 11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Edw. Dore</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWII</u> 16. SOCIAL SECURITY NO. <u>WW II</u> 17. INFORMANT <u>Jett Dore (wife)</u> Address <u>Selma 2</u>		14. MOTHER'S MAIDEN NAME <u>Martha Saddle</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> (c) <u>Coronary Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-26-61</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>1/30/1961</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u>		23. FUNERAL DIRECTOR ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u> 24a. REC'D BY REGISTRAR <u>AM 30 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
SIGNATURE <u>Frank J. Broschart</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			



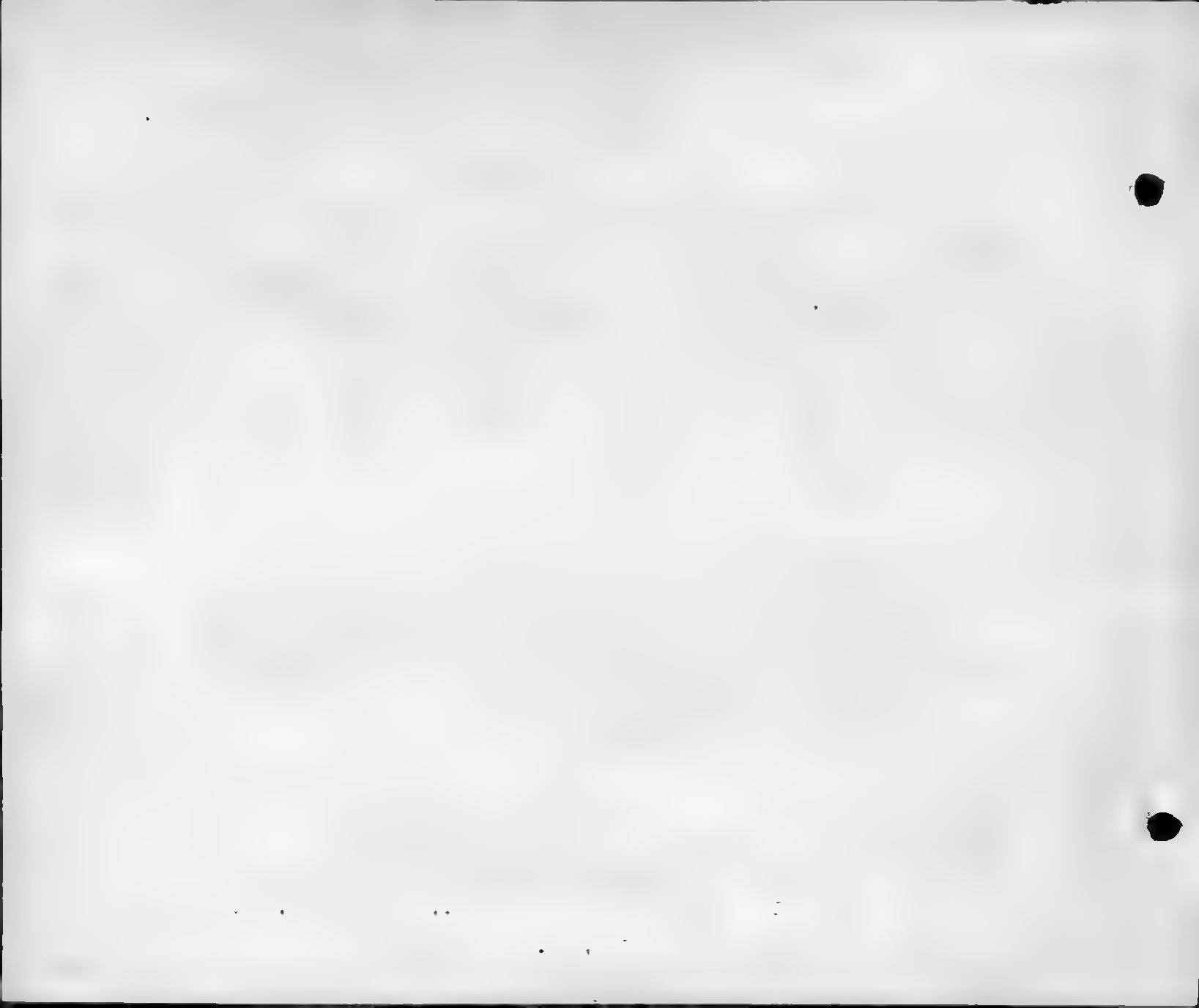
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
811 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
00804									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Monte.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville (rural)</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seven Locks Road</u>					d. STREET ADDRESS <u>Seven Locks Road</u>				
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Martin</u> Last <u>Dove</u>					4. DATE OF DEATH Month <u>Jan.</u> Day <u>25</u> Year <u>19 61</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/1/1885</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Clem Martin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Frances Curtis (daughter) Item 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>Coronary occlusion</u> IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> DUE TO (c) <u>420.1</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> DUE TO (b) <u>420.1</u> DUE TO (c) <u>420.1</u> DUE TO								INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Proschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1/25/61</u>	
EXAMINER'S NAME (Type) <u>Frank J. Proschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/29/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park.,</u>		22d. LOCATION (City, town, or country, (State) <u>Muirkirk, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	

VS. AIME
5M 7/59



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1-28-61 Film 279

Maryland STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

812 60805

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY in 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. STREET ADDRESS R.F.D. # 1 - Spubbs Farm
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) Helen Marion
4. DATE OF DEATH Jan 10 1961

5. SEX female 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH Nov. 17, 1915
8. AGE (In years last birthday) 45 yrs. IF UNDER 1 YEAR: Months 1 Days 23 Hours 10 Min 10

9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY Canada 11. BIRTHPLACE (State or foreign country) Canada
12. CITIZEN OF WHAT COUNTRY? CANADA

13. FATHER'S NAME Charles Marion 14. MOTHER'S MAIDEN NAME Mae Hyland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None 16. SOCIAL SECURITY NO. 970.2 17. INFORMANT Harry Reed

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Barbiturate poisoning
DUE TO (b) 970.2
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 970.2
DUE TO (c) 970.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 1 hr.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported taking 43-1 1/2 gr. Seconal cap at home
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED at work ☐ Not at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) at home 20f. (City or town) Rockville (County) Montgomery (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL EXAMINER'S NAME (Type) Frank J. Boschert M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 1-10-61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/13/61 22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery 22d. LOCATION (City, town, or country) Rockville, Maryland (State) Md.

23. FUNERAL DIRECTOR Robert A Pumphrey ADDRESS Bethesda, Maryland 24a. REC'D BY REGISTRAR Jan 13 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

60806

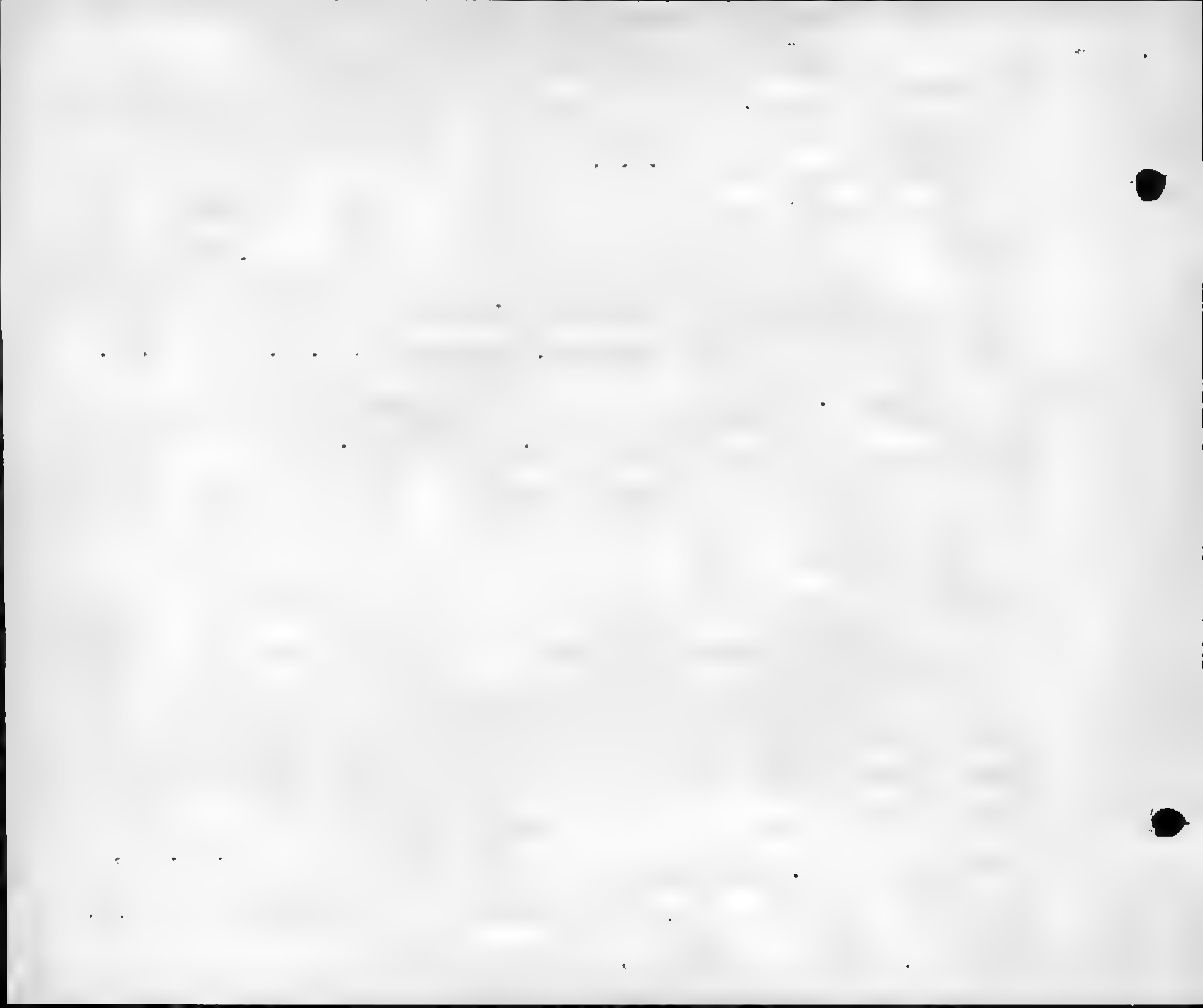
313

Item 3, -- File C280 2-3-61 et

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. STREET ADDRESS 9421 Bulls Run Parkway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle ROCKFORD Last DWYER				4. DATE OF DEATH Month Jan. Day 26, Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 29, 1886	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 0 Days 27		11. IF UNDER 24 HRS. Hours 0 Min. 27			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Research Assoc.			
11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Phillip N. Dwyer				14. MOTHER'S MAIDEN NAME Sidney Harvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 100-1-100000			
17. INFORMANT Wife Mrs. Elizabeth H. Dwyer				Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Jan. 27, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/31/1961		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 30 '61	
				24b. REGISTRAR'S SIGNATURE C. L. Hines			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the funeral director. Page 4 should be executed immediately, writing the word "pending" in pencil in Item 18. Give Reg. No. 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



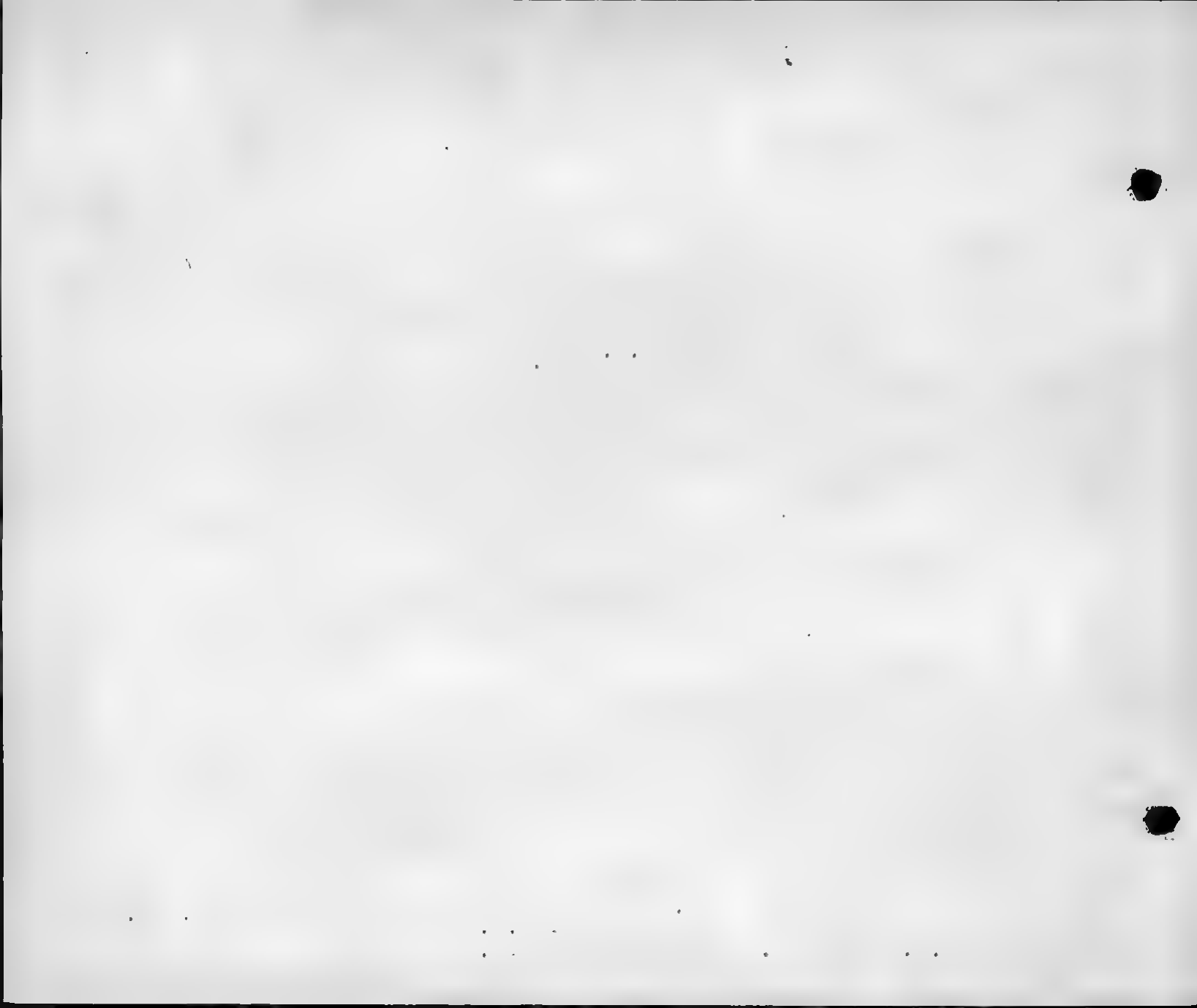
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 yr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9303 Florida Ave</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9303 Florida Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Arthur V. Englert</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>male</u>				6. COLOR OR RACE <u>white</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH <u>5-31-1902</u>			
9. AGE (in years last birthday) <u>58</u> yrs				10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>8</u> Hours <u>1</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral director</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>The S.H. Hines Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>N. J.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Martin Englert</u>				14. MOTHER'S MARRIED NAME <u>Emma Ireland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>418-09-3945</u>			
17. INFORMANT <u>May Englert</u>				18. ADDRESS <u>Steu 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-18-61</u>			
Address (Street, city, town, or county) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>1/21/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>				22d. LOCATION (City, town, or country) <u>Prince Georges, Md.</u> (State) _____			
23. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
24b. ADDRESS <u>2901 14th St. N.W.</u>				24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
24d. WASHINGTON 9, D.C.				DATE <u>JAN 23 '61</u>			

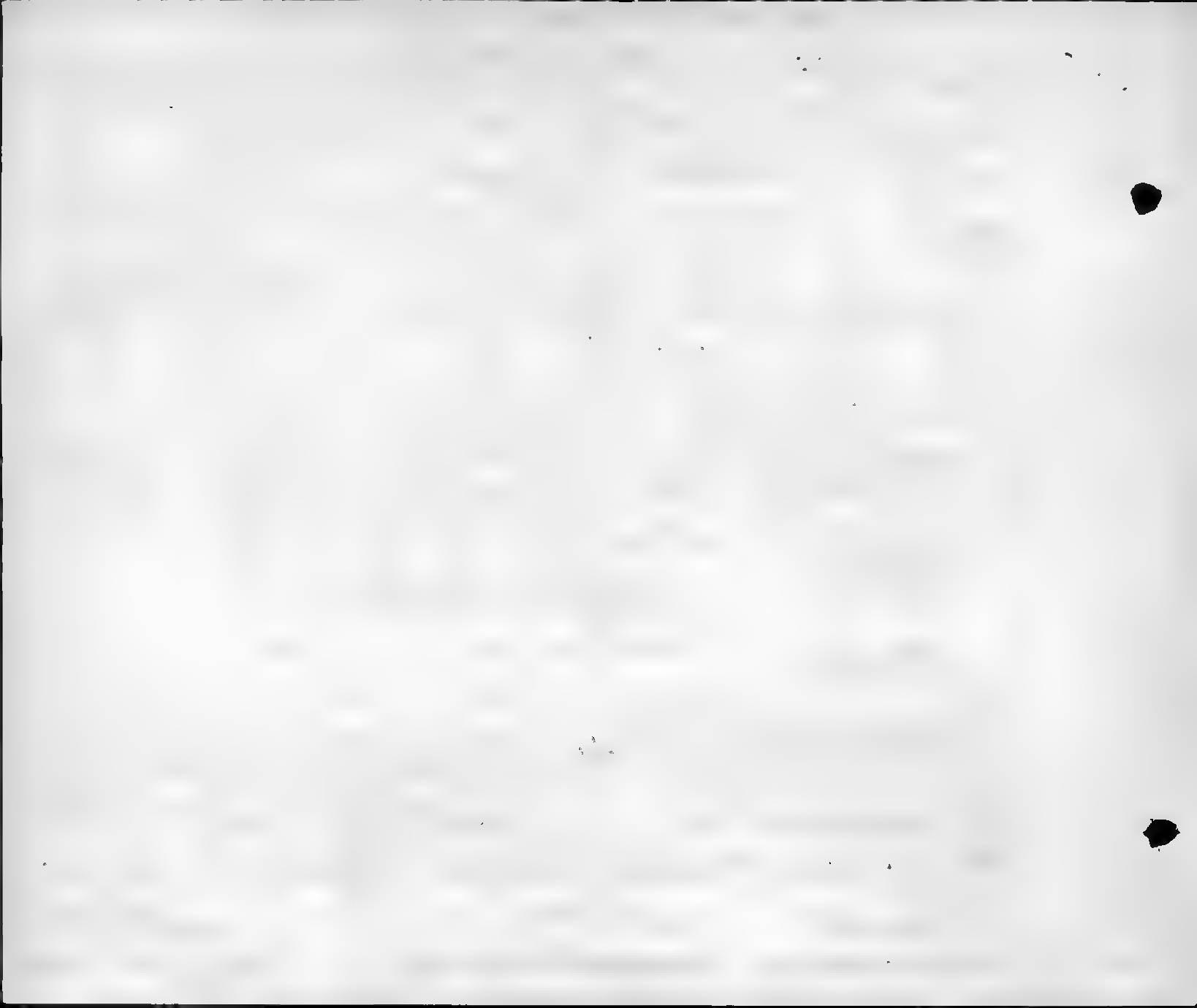


315

CERTIFICATE OF DEATH

Reg. Dist. No. 00808

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5625 Oak Place				d. STREET ADDRESS 5625 Oak Place			
3. NAME OF DECEASED (Type or print) First Edwin Middle C Last Estes				4. DATE OF DEATH Month Jan Day 6 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1888	
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months 4 Days 22		IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME David Estes				14. MOTHER'S MAIDEN NAME Sue Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Anna S. Estes-wife-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 months 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/1 , 19 60 , to 1/6/61 , 19 61 , that I last saw the deceased alive on 1/6 , 19 61 , and that death occurred at 9:30 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr Joseph Kenrick		M.D. 6450 Wisconsin Ave, Bethesda, Md, 1/6/61		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr JOSEPH KENRICK		6450 Wisconsin Ave., Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/61		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JAN 10 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
3
816
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00869

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ETHEL GREEN HALL DR</u>		d. STREET ADDRESS <u>ETHEL GREEN HALL DR</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Esther</u> Last <u>Esther</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>THEODORE ESTIER</u>		14. MOTHER'S MAIDEN NAME <u>IDA MORRE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>KATHERINE ESTIER</u>		Address <u>4411 W. 11th Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> causing the under-lying cause last. (c) <u> </u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>May 5, 1952</u> to <u>Jan 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 5, 1961</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Russell B. Arnold</u> M.D.		22b. DATE SIGNED <u>11 Jan 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		22d. ADDRESS <u>8201 Oakville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>1-11-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Wash D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Wash D. C.</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 12 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

(M)

(I)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

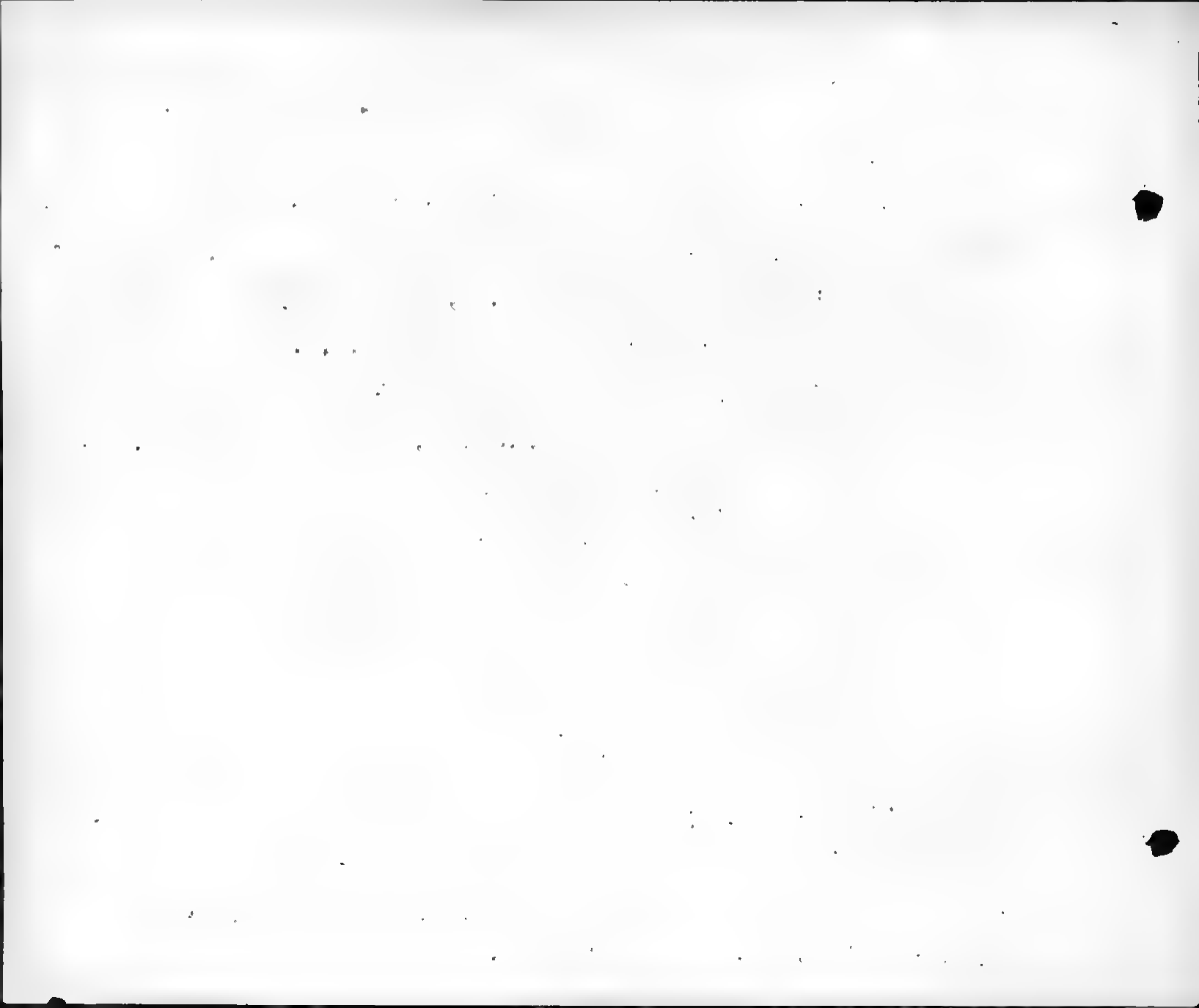
817

CERTIFICATE OF DEATH

Reg. Dist. No. **60810**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rockville</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverley Sanitarium</u>				d. STREET ADDRESS <u>10411 Amherst Ave.,</u>			
3. NAME OF DECEASED (Type or print) <u>Eleano r</u> <u>SHERMAN</u> <u>Ewing</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1875</u> <u>Dec. 15, 1898</u>		9. AGE (In years last birthday) <u>84</u> <u>85</u> yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles Ewing</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mr. Allwine, Waverley Sanitarium.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>4200</u> DUE TO <u>Hypertension</u> <u>Chronic Arteriosclerosis</u> <u>Chronic Arteriosclerosis of Heart & Coronaries</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>under</u> lying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>October</u> 19 <u>60</u> , to <u>Jan 7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>61</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert T. Thiradine</u> M.D.		ADDRESS (Street, city or town, state) <u>10411 Amherst Ave., Silver Spring, Md.</u>					
PHYSICIAN'S NAME (Type) <u>ROBERT T. THIRADINE</u>		DATE SIGNED <u>Jan 12 '61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/11/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Jan 12 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10811

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN b. 7 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9910 LORAIN AVENUE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 19910 LORAIN AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last STANLEY LIVINGSTON FANT, SR.		4. DATE OF DEATH Month Day Year JAN. 1 1961	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/22/03	
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY U. S. GOV'T. POST OFFICE	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE PAYNE FANT		14. MOTHER'S MAIDEN NAME BLANCHE MAY WELCH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW # 2		16. SOCIAL SECURITY NO. 377-16-1503	
17. INFORMANT Mrs. Blanche M. Welch		Address 9910 Lorain Ave. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (b) 422.1 (c), stating the underlying cause test, 422.1 DUE TO (c) 422.1		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 1/2/61	
EXAMINER'S NAME (Type) FRANK J. BROSCART		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/4/61	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or country) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR REYNOLD E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR JAN 6 '61	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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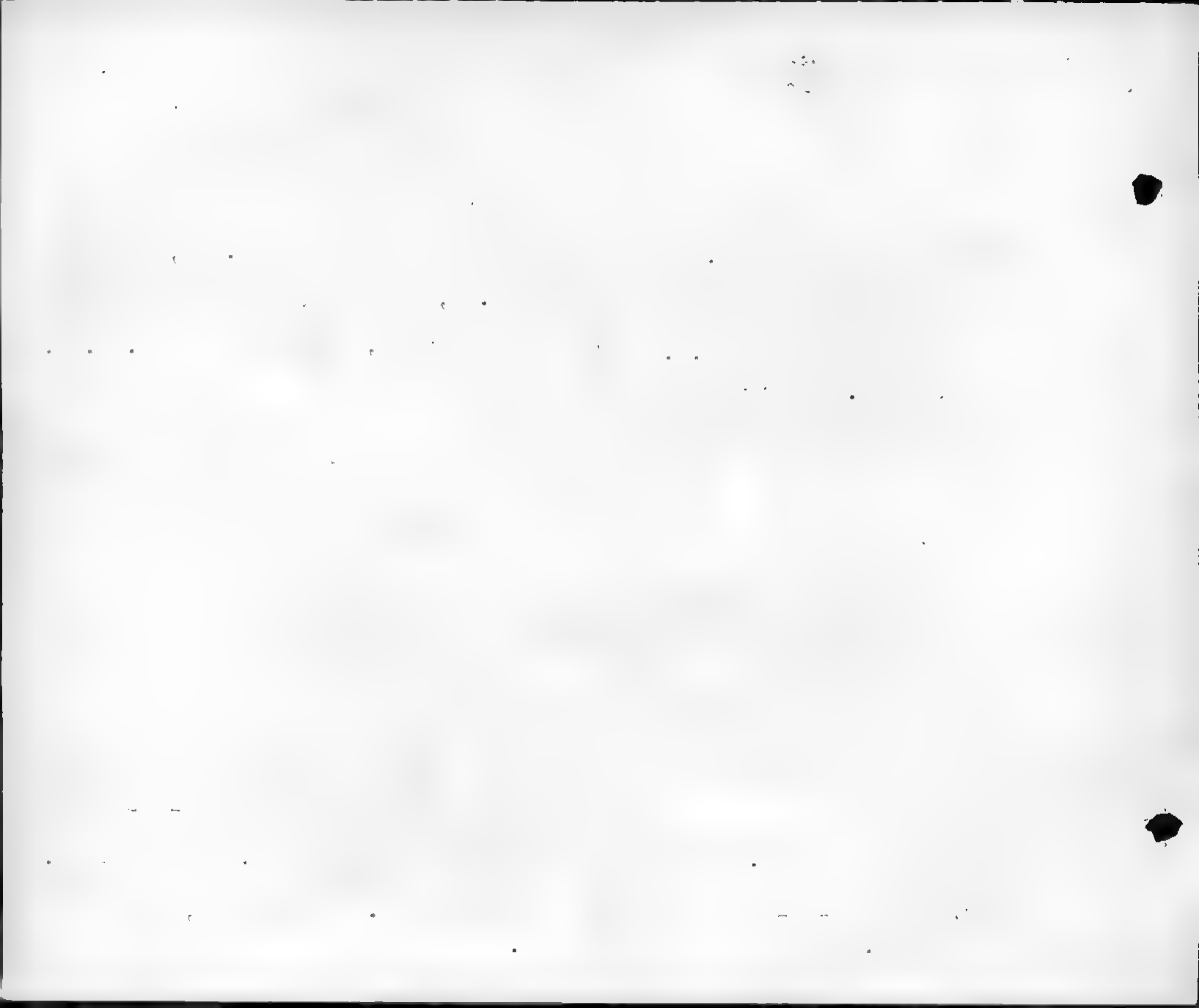
may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00812

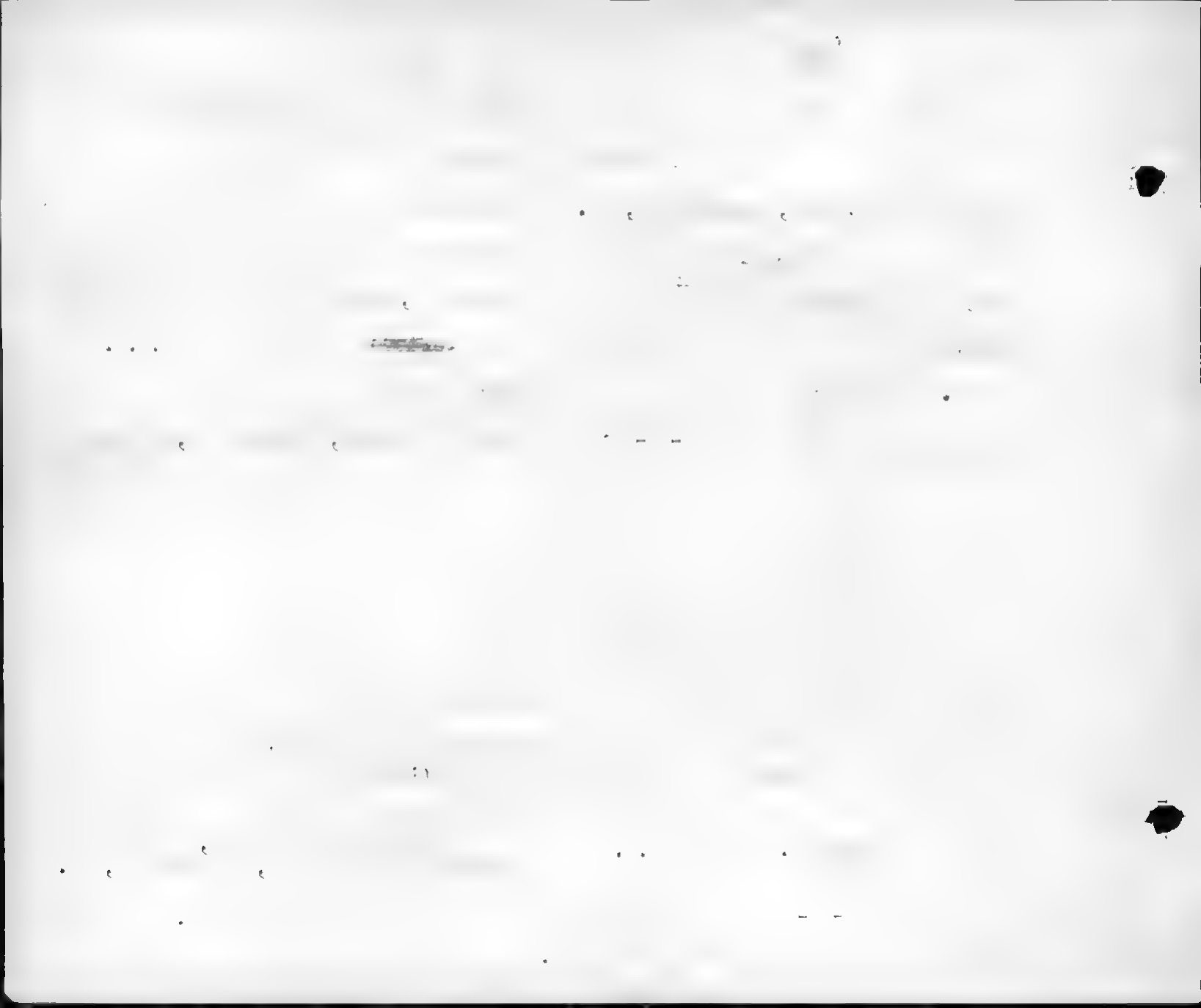
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1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 50			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE H. FEATHERSTONHAUGH				4. DATE OF DEATH Month Day Year Jan. 20, 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1892	9. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Marion, Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John M. Hickman				14. MOTHER'S MAIDEN NAME Rose McKenna			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT William Featherstonhaugh - Son Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 1720-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO CORONARY ARTERIOSCLEROTIC HEART DISEASE DUE TO 3 MRS						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) POLYCYTHEMIA VERA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 to JAN 20, 1961 , that (I) (we) last saw the deceased alive on JAN 20, 1961 , and that death occurred at 9:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE John H. Touhy				22b. DATE SIGNED 1-21-61			
22c. PHYSICIAN'S NAME (Type) JOHN H. TOUHY				22d. ADDRESS 7720 Wisconsin Ave., Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-24-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				25a. REC'D BY REGISTRAR Bethesda, Md.		25b. REGISTRAR'S SIGNATURE DATE JAN 25 '61	



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 820
 CERTIFICATE OF DEATH
 00813

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		f. STREET ADDRESS Route # 1	
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Samuel Middle William Last Finneyfrock				4. DATE OF DEATH Month January Day 15 Year 1961			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 10, 1902	
9 AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.		IF UNDER 24 HRS Months 58 Days 58 Hours 58 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Concrete		11. BIRTHPLACE (State or foreign country) Ireland Redland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ora B. Finneyfrock				14. MOTHER'S MAIDEN NAME Cora Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-05-5584		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchogenic carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____ 21 I certify that (I) (this hospital) attended the deceased from December 27 1961 , to January 15 1961 , that (I) (we) last saw the deceased alive on January 15 1961 , and that death occurred at 7:55AM from the causes and on the date stated above. 22a. SIGNATURE Robert B. Scoggins M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 1/15/61 22b. ADDRESS The Clinical Center, National Institute of Health, Bethesda 14, Md. 22c. PHYSICIAN'S NAME (Type) Robert B. Scoggins M.D. 22d. DATE SIGNED 1/15/61 23a. BURIAL CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1-17-61 23c. NAME OF CEMETERY OR CREMATORY Laytonsville 23d. LOCATION (City, town, or county) (State) Laytonsville, Md. 24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber Laytonsville, Md. 25a. REC'D BY REGISTRAR JAN 19 '61 25b. REGISTRAR'S SIGNATURE Arthur L. House							



TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

3
821
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00814

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lewisdale</i>	
3. NAME OF DECEASED (Type or print) <i>Clarence</i> First <i>Arthur</i> Middle <i>Fletcher</i> Last		4. DATE OF DEATH <i>1-12-1961</i> Month <i>1</i> - Day <i>12</i> - Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-31-86</i>
9. AGE (In years and birth day) <i>74</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Va.</i>	
11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Fletcher</i>		14. MOTHER'S MAIDEN NAME <i>Mary Janie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Washington Sanitarium & Hosp. Records</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO <i>ingestive lead failure & Bronchopneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>admission of stomach</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>3 days</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12/30</i> 19 <i>60</i> to <i>1/12</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>1/12</i> 19 <i>61</i> , and that death occurred at <i>11:30</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>W.R. Moses</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>W.R. Moses</i>		22d. ADDRESS <i>1835 Eye St N.W.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>1/16/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>CEAR HILL</i>		23d. LOCATION (City, town, or county) (State) <i>SUITLAND MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hankon Funeral Home - 3831 GA Ave</i>		25a. REC'D BY REGISTRAR <i>W</i> 25b. REGISTRAR'S SIGNATURE <i>James S. Hanna</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

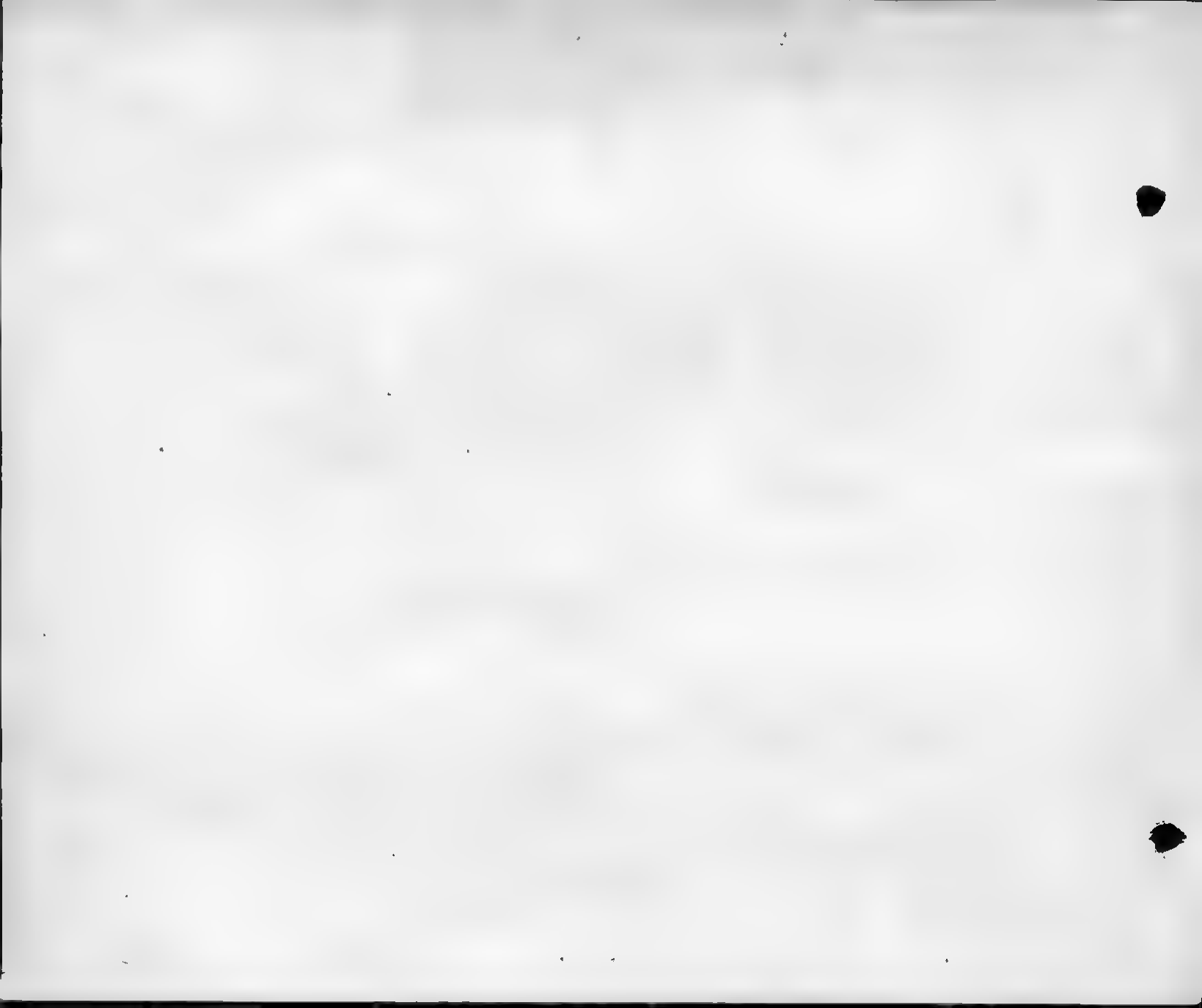
822

00815

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sand Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prinlee</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>2104 Cool Spring Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Forney</u> First Middle Last		4. DATE OF DEATH <u>1</u> / <u>13</u> / <u>1961</u> Month Day Year	
5. SEX <u>F</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5</u> 9. AGE (in years last birthday) <u>79</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Binder</u>		14. MOTHER'S MAIDEN NAME <u>Marie Pauli</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Helen L. Wilson</u>		Address <u>Hyattsville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> (b) <u>left congestive heart failure</u> (c) <u>due to</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>1-2</u> <u>1956</u> , to <u>1-13</u> <u>1961</u> , that (1) (we) last saw the deceased alive on <u>1-13</u> <u>1961</u> , and that death occurred at <u>2:33 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. D. Bauer, M.D.</u>		22b. DATE SIGNED <u>1-13-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. D. Bauer, M.D.</u>		22d. ADDRESS <u>2513 Buck Lodge Rd Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 17, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hyattsville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>JAN 16 '61</u>	
Address <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Caroline S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

823

CERTIFICATE OF DEATH

Reg. Dist. No. 60816

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 4 1/2 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 SILVER SPRING			
1 d. STREET ADDRESS 1634 BELVEDERE BLVD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH BINDER GABERMAN				4. DATE OF DEATH Month Day Year JAN. 26 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 20, 1886	
9. AGE (In years lost birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME NOAH BINDER				14. MOTHER'S MAIDEN NAME RACHEL (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-09-6678 D		INFORMANT MRS N. JOEL		Address 1634 BELVEDERE BLVD S.S.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Generalized Arterio Sclerosis - DUE TO Arterio Sclerosis C.V.R. disease - DUE TO Deaths Thrombotic - Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH 1-2 1/2 yrs 3 yrs 12 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-10- 19 49 , to 1-26 19 61 , that I last saw the deceased alive on 1-25- 19 61 , and that death occurred at 4:00 a.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin M.D.				ADDRESS (Street, city or town, state) 6124 - Central Ave			
PHYSICIAN'S NAME (Type) WILLIAM BRAININ M.D.				DATE SIGNED Capital Hto Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-29-61		22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY		22d. LOCATION (City, town, or county) (State) HYATTSVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE B Danyawsky & Sons				ADDRESS 3501-14th St NW		24a. REC'D BY REGISTRAR DATE FEB 1 '61	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66817

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm. session) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN Ia D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 CA IN JOHN	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUURLIN		d. STREET ADDRESS 7601 Cabin Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSE EVELYN GAMBLE		4. DATE OF DEATH Jan 26 1961		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/18/77		9. AGE (In years, last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician Scientist practitioner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Martha M. Atter - 3835 Leighton St. Chevy Chase Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Frank J. Broschert		22a. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		22b. LOCATION (City, town, or country) (State) Bladensburg Rd. Md.	
22c. DATE THEREOF 1/29/61		22d. REC'D BY REGISTRAR DATE JAN 31 '61		22e. REGISTRAR'S SIGNATURE Arthur S. Kiser	
23. FUNERAL DIRECTOR Chevy Chase Funeral Home Wash. DC		23a. ADDRESS 5103 Wood		23b. REGISTRAR'S SIGNATURE	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1703 EAST-WEST HIGHWAY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS CONTINENTAL HOTEL			
3. NAME OF DECEASED (Type or print) MAURICE First Middle Last		4. DATE OF DEATH JAN. 2 1961 Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX MALE 6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 12/20/02 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Mins.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney 13. FATHER'S NAME Henry Garber		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Justice 11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Torf Funeral Service Address 1615 Beacon St, Boston,			
14. MOTHER'S MAIDEN NAME Elizabeth Garber		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.					
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J Broschart</i> M.D. EXAMINER'S NAME (Type) FRANK JY BROSCHART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/2/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/2/61		22c. NAME OF CEMETERY OR CREMATORY Torf Funeral Service			
22d. LOCATION (City, town, or country) (State) Boston, Mass.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>					

Seeley Sullivan 4217-9-see



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

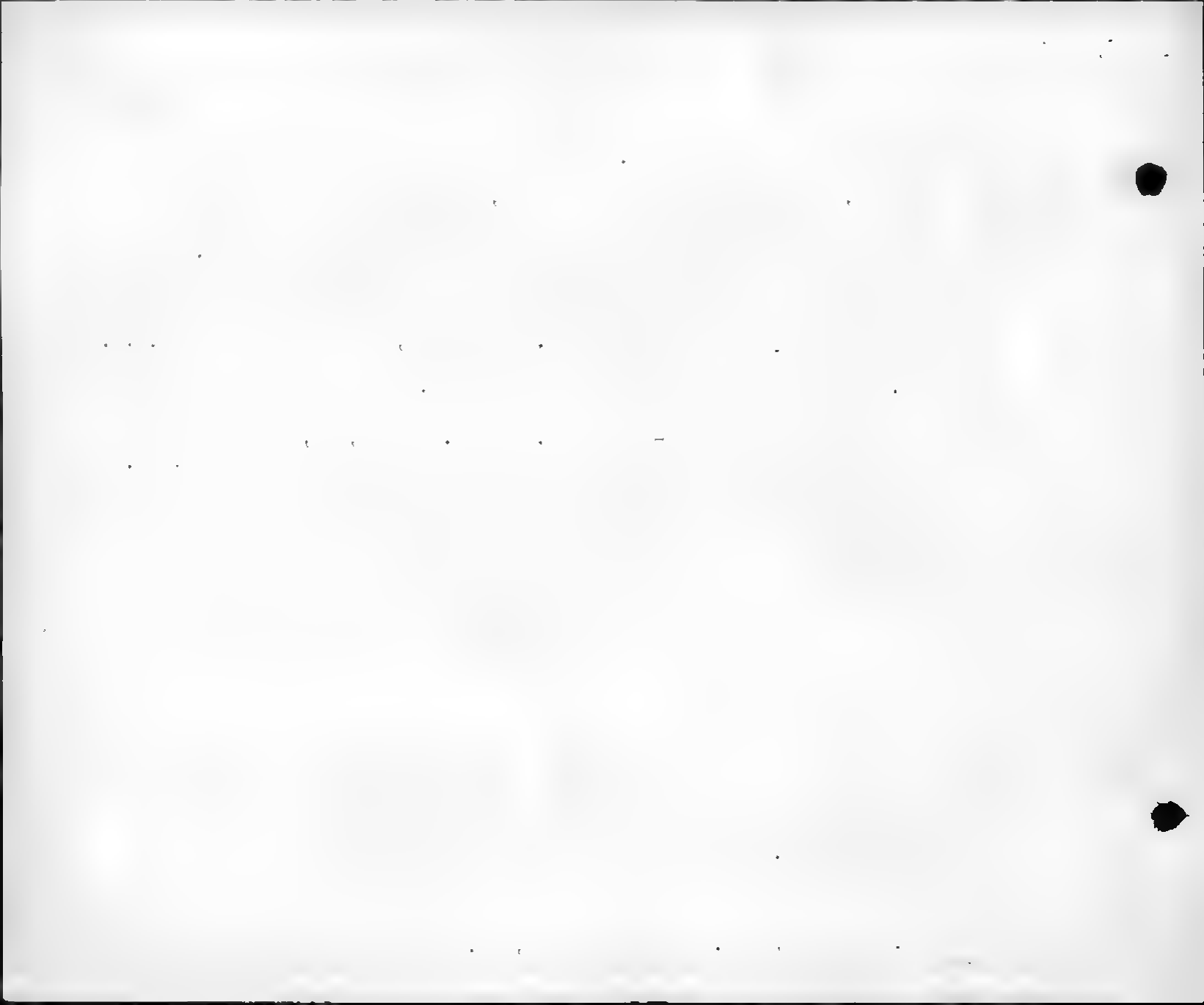
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00810

326

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 1 1/2 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13,203 KARA LANE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 13,203 KARA LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GLANDVILLE Middle LaMOTTE Last GIBSON		4. DATE OF DEATH Month JAN. Day 22 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/09
9. AGE (In years, last birthday) 51 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receiving Stock Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Sears Roebuck Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank E. Gibson		14. MOTHER'S MAIDEN NAME Cora B. Reeling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 577-09-5634	
17. INFORMANT Mrs. Edna S. Gibson, 13,203 Kara Lane		Address Silver Spring, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 day DUE TO (c) 1 day		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 52 to 22 Jan, 1961 , that I last saw the deceased alive on 22 Jan 19 61 , and that death occurred at 3:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud M.D.		ADDRESS (Street, city or town, state) 9026 Calverville Rd Silver Spring, Md	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD		DATE SIGNED 1/22/61	
22a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		22b. DATE THEREOF 1/25/61	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM E. PUMPHREY, INC. Raymond A. Zicka		24a. REC'D BY REGISTRAR JAN 26 '61	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE C. J. H. H. H.	



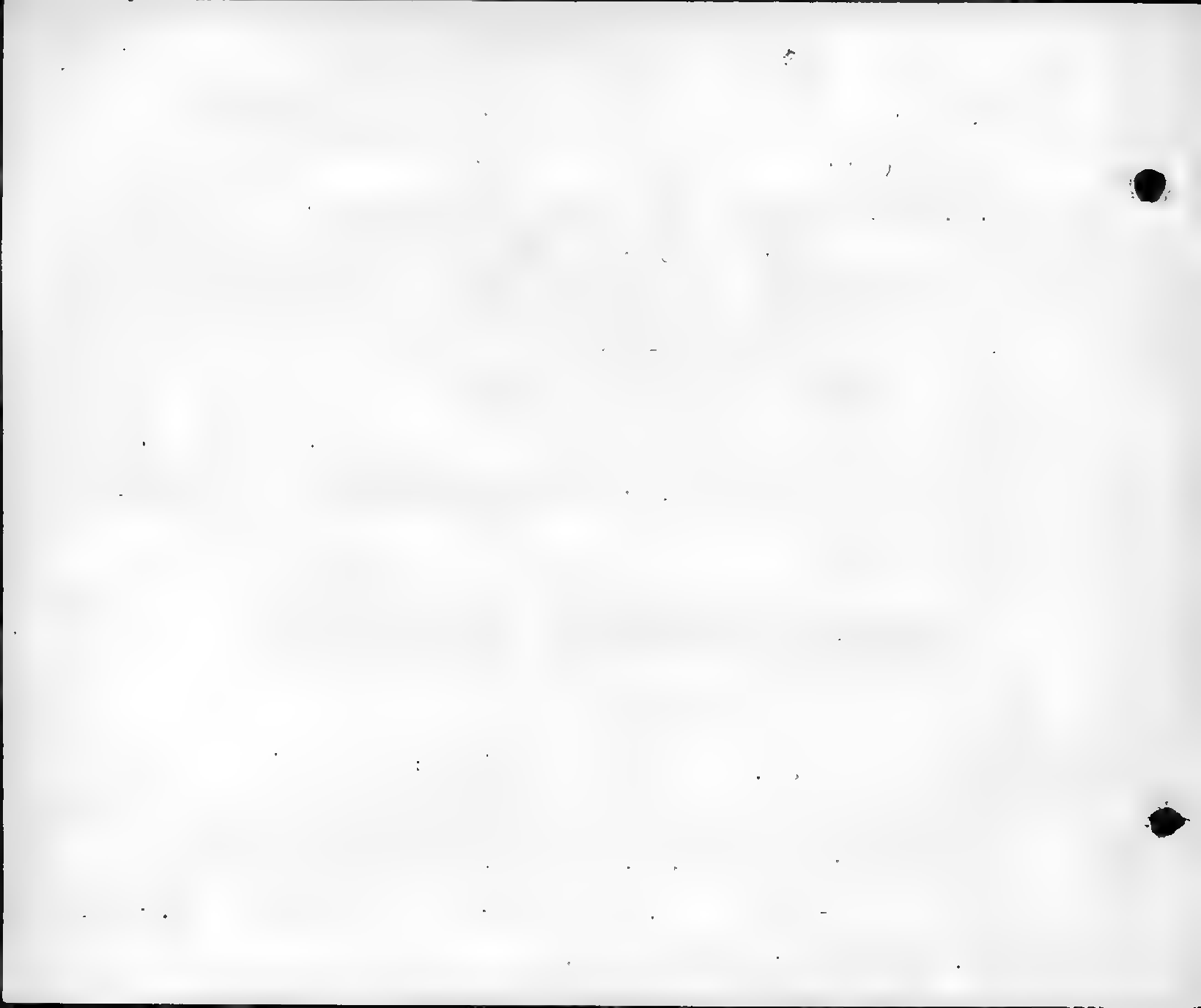
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66820

827

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5813 Greenlawn Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) First Middle Last Mark Clarence GILCHRIST				4. DATE OF DEATH Month Day Year January 11 1961					
5 SEX Male		6. COLOR OR RACE Caucasian		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 2-11-59		9 AGE (In years last birthday) 1 yrs 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --- 10b. KIND OF BUSINESS OR INDUSTRY --- 11. BIRTHPLACE (State or foreign country) Argentina 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David M. GILCHRIST				14. MOTHER'S MAIDEN NAME Charlotte Maie RITTER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17 INFORMANT Address (F) David M. Gilchrist, same as #2 above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess, brain, organism undetermined DUE TO (b) 342X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital Heart Disease, Cyanotic 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21 I certify that (X) (this hospital) attended the deceased from Jan. 9 1961 to Jan. 11 1961, that (X) (we) last saw the deceased alive on Jan. 11 1961, and that death occurred at M. from the causes and on the date stated above									
22a SIGNATURE <i>Robert V. Rack</i>				22b DATE SIGNED 1-11-61					
22c PHYSICIAN'S NAME (Type) Robert V. Rack, LT, MC, USN				22d ADDRESS u. s. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-14-60		23c NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d LOCATION (City, town, or county) (State) Randallstown Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i>				25a. REC'D BY REGISTRAR JAN 13 61 DATE					
25b. REGISTRAR'S SIGNATURE <i>William S. Haines</i>				25c. REGISTRAR'S NAME William S. Haines					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 9/59

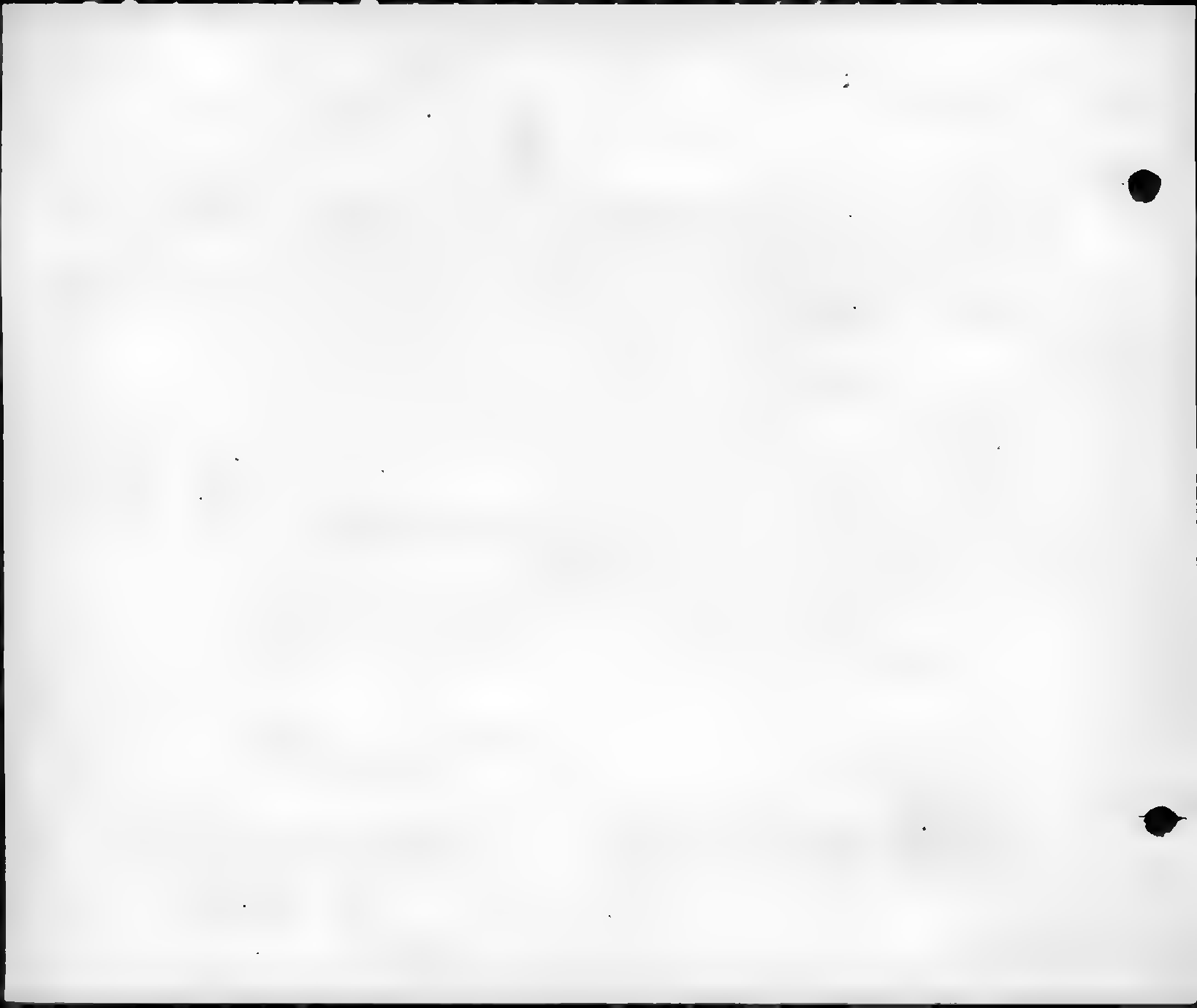
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

328

CERTIFICATE OF DEATH

00821

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pri. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>				c. LENGTH OF STAY IN 1b <u>1150-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				e. STREET ADDRESS <u>1409 - Asbury Court</u>			
3. NAME OF DECEASED (Type or print) <u>Baley</u> First Middle Last				4. DATE OF DEATH <u>1</u> Month <u>2</u> Day <u>1961</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-61</u>	
9. AGE (in years last birthday) <u>15</u> yrs.		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Francis Xavier Gleeson</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Ann Ellis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mother's chart</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>750X</u> DUE TO <u>anencephalic edema of newborn & meningeal coarctation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>meningeal coarctation</u> (c) <u>meningeal coarctation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m p m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12:45 P.M. 1-2-61</u> to <u>12:50 P.M. 1-2-61</u> , that (I) (we) last saw the deceased alive on <u>1-2-61</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul E. Egan</u> M.D.				22b. ADDRESS <u>6727-16th St. N.E., Wash. D.C.</u>			
22c. PHYSICIAN'S NAME (Type) <u>PAUL E. EGAN M.D.</u>				22d. DATE SIGNED <u>1-2-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-4-61</u>				23b. DATE THEREOF <u>1-4-61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>				23d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hawthorne Funeral Home</u> ADDRESS <u>3831 - GA AVE. N.W.</u>				25. REGISTRAR'S SIGNATURE <u>Chas. A. Thomas</u>			
26. REC'D BY REGISTRAR <u>JAN 10 '61</u>							



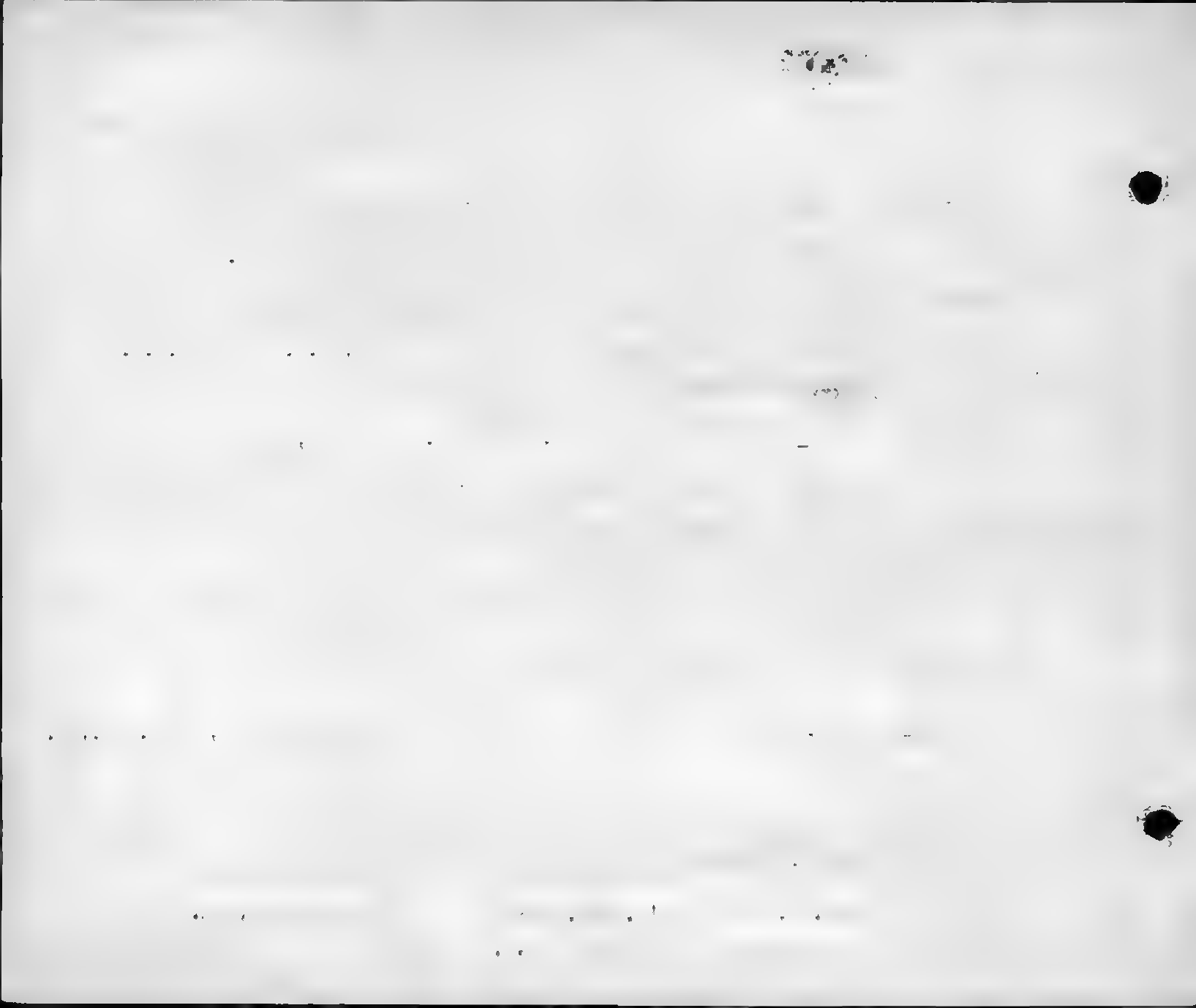
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
829 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 60822														
1. PLACE OF DEATH a. COUNTY MONTGOMERY					2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING					c. LENGTH OF STAY IN 1b 27 years									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8113 GROVE STREET					d. STREET ADDRESS 8113 GROVE STREET									
3. NAME OF DECEASED (Type or print) NORMA					4. DATE OF DEATH JAN. 7 19 61									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/22/05		9. AGE (in years last birthday) 55 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) NEW YORK CITY, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HARRY					14. MOTHER'S MAIDEN NAME CLARA (Unknown)									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No					16. SOCIAL SECURITY NO. None					17. INFORMANT Mr. Philip R. Goldstein, 8113 Grove Street Silver Spring, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage and laceration DUE TO bullet wound thru skull Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										BETWEEN ONSET AND DEATH sudden				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflecting bullet thru skull									
20c. TIME OF INJURY Month, Day, Year 9:22am Jan. 7 1961					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Silver Spring, Mont. Co., Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCART					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 1/7/61				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Jan. 9, 1961		22c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park		22d. LOCATION (City, town, or country) (State) Falls Church, Va.					
23. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th Street N.W.					24a. REC'D BY REGISTRAR JAN 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							



830

CERTIFICATE OF DEATH

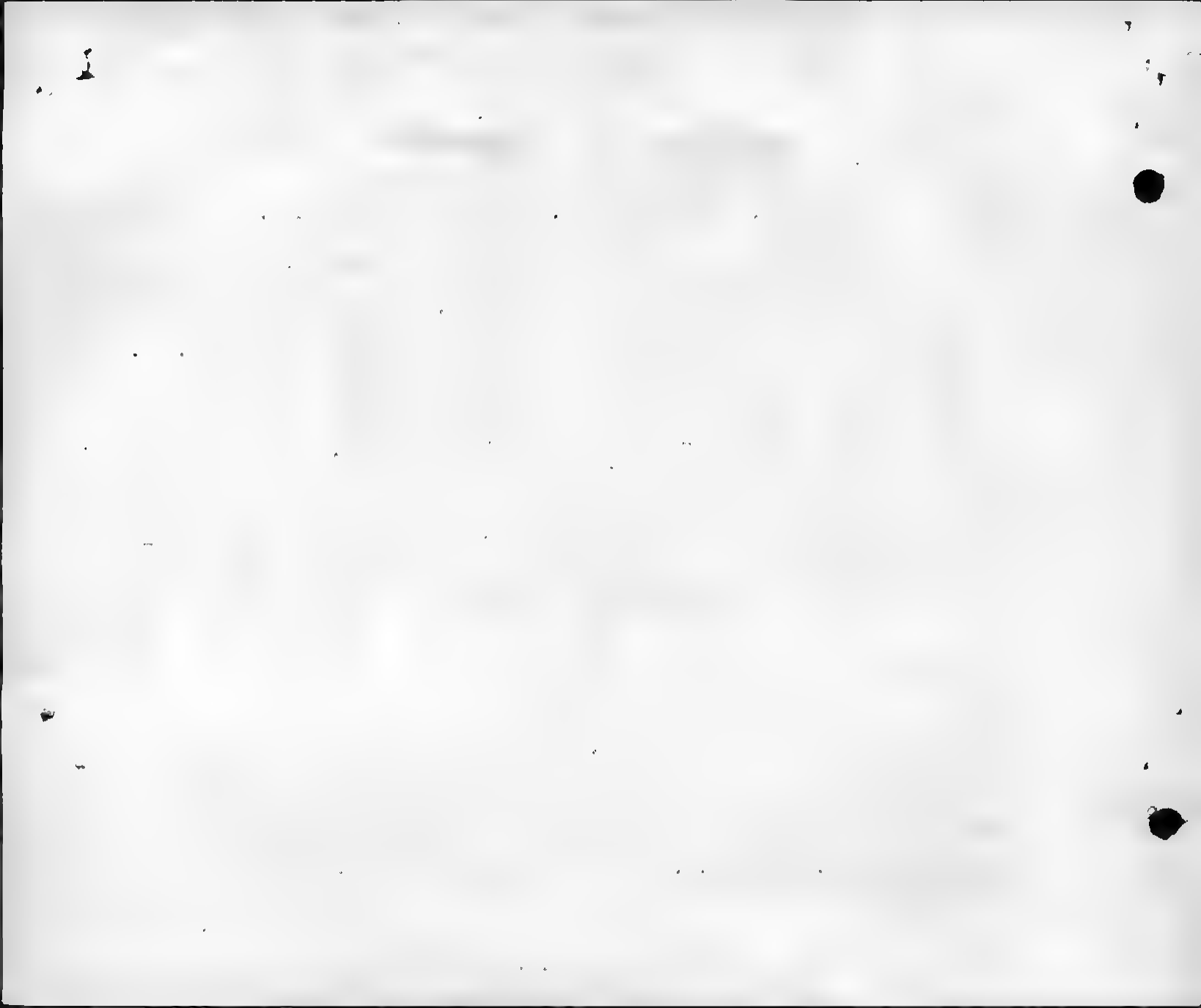
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admssn on) a. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>21 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Alice</u> Last <u>Gooding</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	9. AGE (In years last birthday) <u>40</u> yrs.
13. FATHER'S NAME <u>Frank Currence</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY NO. <u>579-28-8144</u>		17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Bilateral ureteral obstruction</u> DUE TO (c) <u>Carcinoma of the cervix</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>3-4 weeks</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>December 12, 19 60</u> to <u>January 2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>January 2</u> , 19 <u>61</u> , and that death occurred at <u>11:40 A</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>1/3/61</u> ACTUAL SIGNATURE <u>J. H. Bains M.D.</u> M.D. <u>The Clinical Center</u> PHYSICIAN'S NAME (Type) <u>JERRY W. BAINS, M.D.</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/5/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>	22d. LOCATION (City, town, or county) (State) <u>Highland Park, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Kisher</u>		ADDRESS <u>1432 Lou Street, N.W.</u>	24a. REC'D BY REGISTRAR DATE <u>JAN 6 '61</u>
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



DISTRICT OF COLUMBIA: S. S.

WE/I,

upon our/my oath do depose and say: that, Mary Alice Gooding

who died January 2, 1961

in the District of Columbia

was our/my Wife

; and, that for a long time prior to his/her death was

known and referred to as Alice Gooding

, and that Mary Alice Gooding

and Alice Gooding

is one and the same person.

IN WITNESS WHEREOF we/I have hereunto set our hands and seal in duplicate, this 4th

day of

Jan

19 61

FORBIDDEN AND SWORN TO
BEFORE ME THIS 4th DAY

OF Jan

19 61

Herbert R. Buschauer

4 Mary Alice Gooding

BY COMMISSIONER OF DISTRICT OF COLUMBIA

1962



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

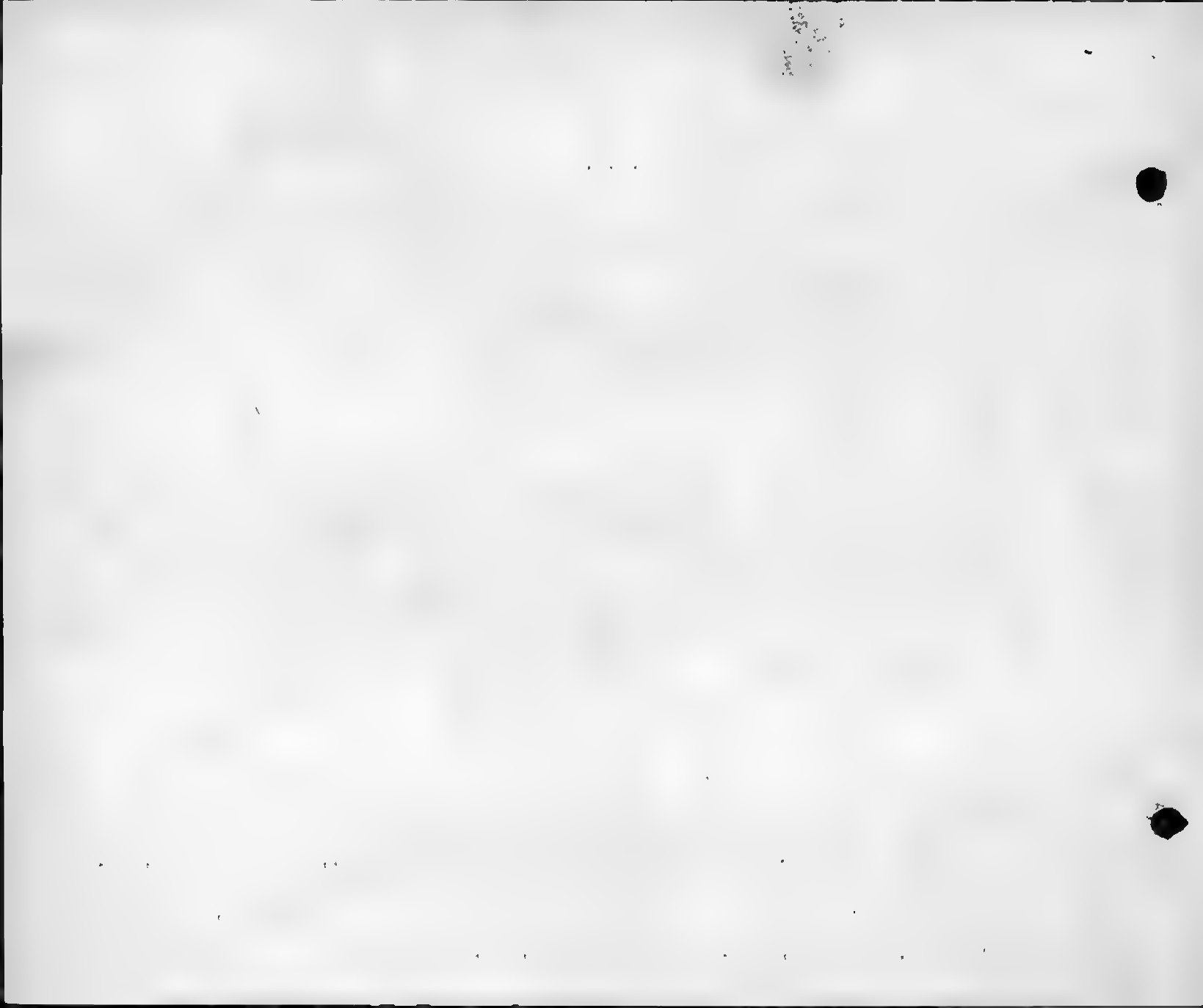
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

831

60824

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in lb. <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1224 Blair Mill Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joyce Kay Goodwin</u> First Middle Last 5. SEX <u>F.</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 4-60</u> 9. AGE (In years, last birthday) yrs. <u>1</u> months <u>5</u> days <u>17</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Mont Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Mr. William C. Goodwin</u> 14. MOTHER'S MAIDEN NAME <u>Ruby K. Mums</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Mr. William C. Goodwin</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Upper respiratory infection</u> (c) <u>10 min</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. <u>11:18</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> 19 <u>1961</u> , to <u>1/20</u> 19 <u>1961</u> , that (I) (we) last saw the deceased alive on <u>1/18</u> 19 <u>1961</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>James R. Coleman M.D.</u> 22b. DATE SIGNED <u>1/20/61</u> 22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u> 22d. ADDRESS <u>733 Sligo Ave., Silver Spring, Md.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>1/23/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u> 23d. LOCATION (City, town or county) <u>ARLINGTON, VIRGINIA</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred E. Dimpney, Inc.</u> 25a. REC'D BY REGISTRAR <u>JAN 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Montgomery Co. Medical Examiner notified and released to hospital.

VR A15 (4)
15M 9/59

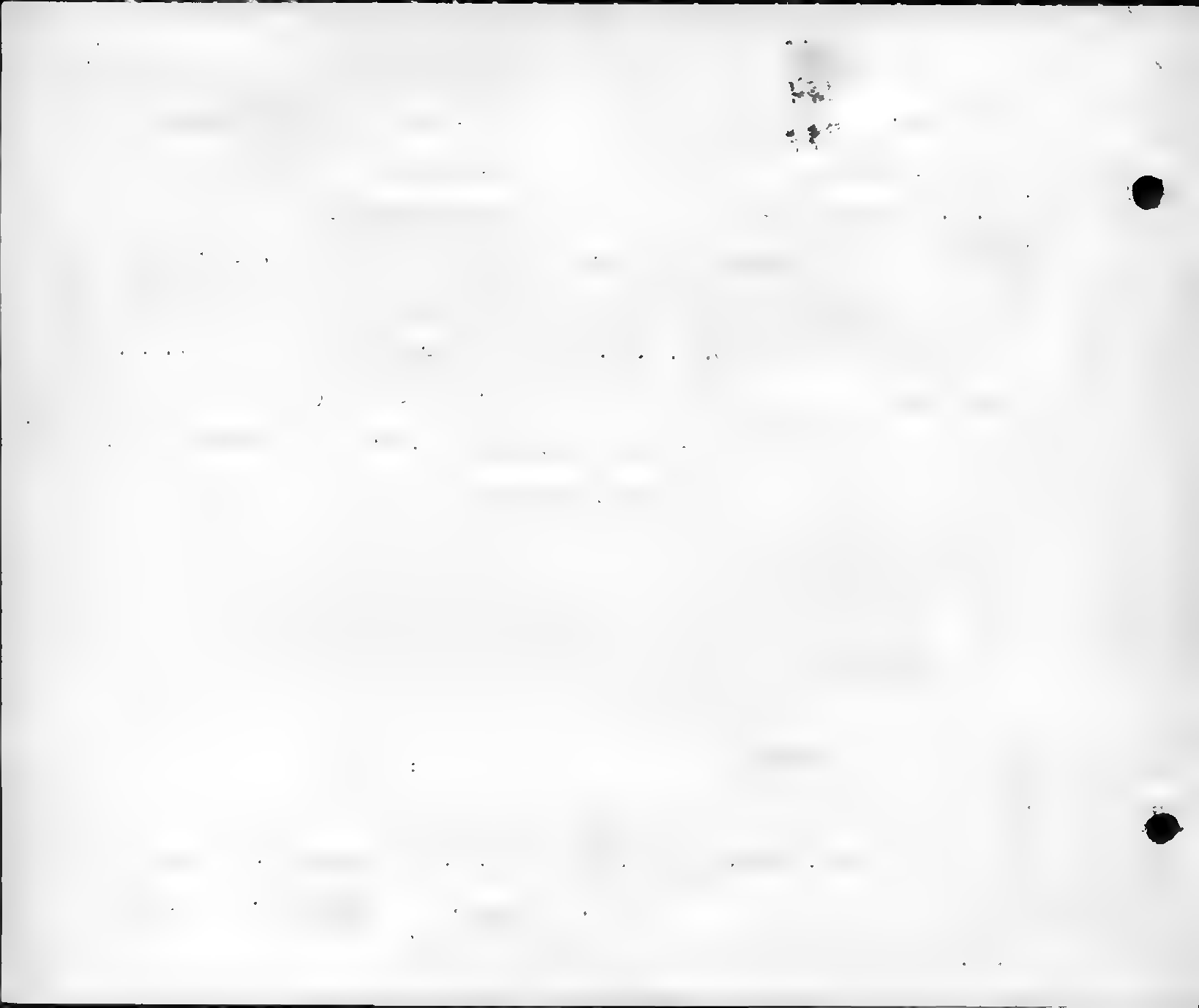
832

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60825

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 3402 McComas Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clayton William GRAY		4. DATE OF DEATH Month Day Year January 31 1961	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-27-00
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Clark GRAY		14. MOTHER'S MAIDEN NAME Sarah Elizabeth (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO 577-09-9659	
17. INFORMANT (S) Clayton A. Gray, 2300 Blueridge Ave. Wheaton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction myocardium 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the deceased attended the deceased from DOA 9:45 PM to DOA , 19____, that (I) the last saw the deceased alive on DOA 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Paul G. Linaweaver</i>		22b. DATE SIGNED 2-1-61	
22c. PHYSICIAN'S NAME (Type) Paul G. LINAWEAVER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. Humphrey</i>		25. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	
ADDRESS W. E. Humphrey Funeral Home, 8434 Georgia Ave.		DATE FEB 7 '61	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-10
15M 8/59

333

MARYLAND STATE DEPARTMENT OF HEALTH

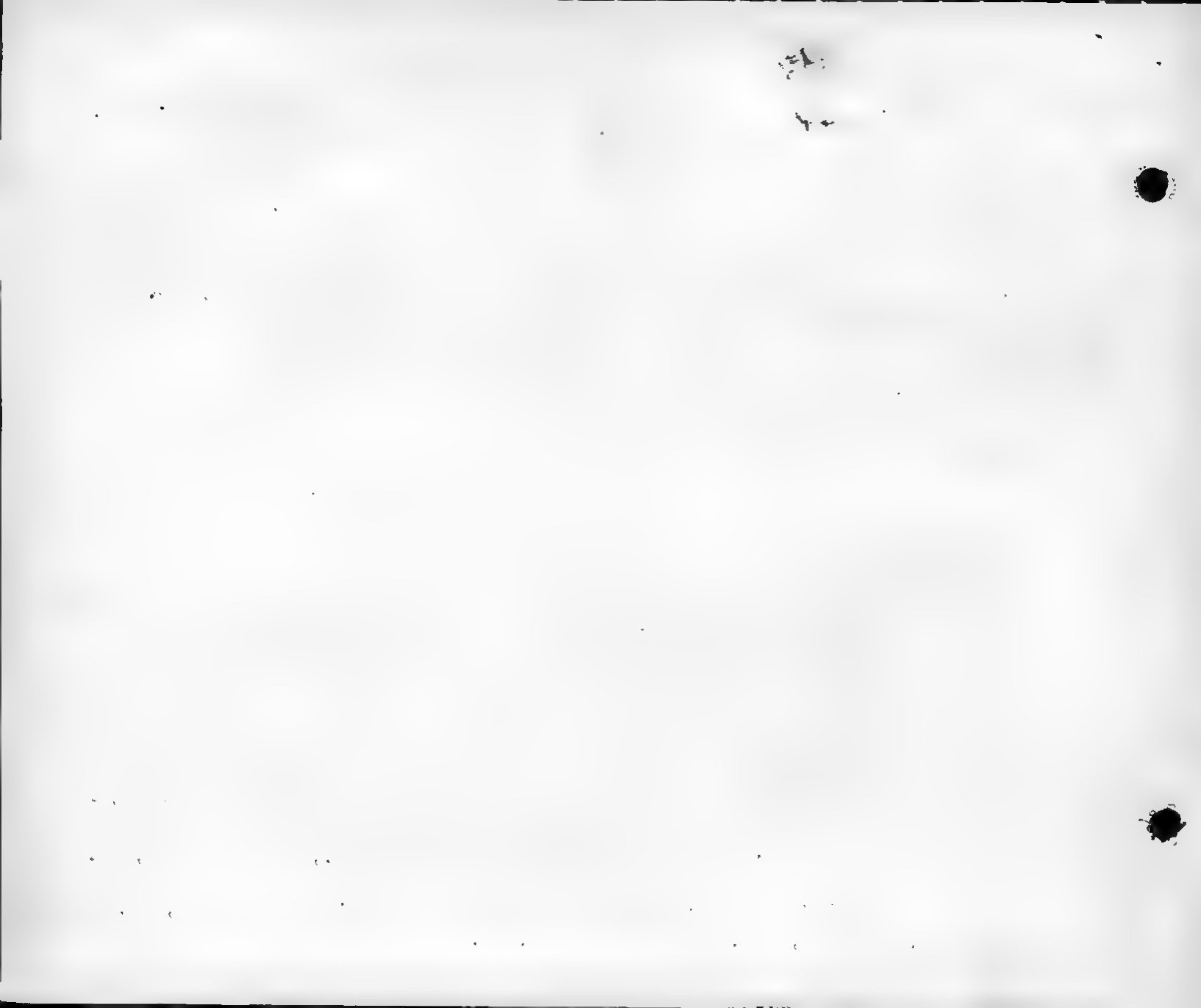
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00826

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		d. STREET ADDRESS <u>1409 Langley Way</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marilyn</u> Middle <u>Christine</u> Last <u>Greeley</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1961</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-29-60</u>
9. AGE (In years last birthday) yrs <u>4</u> Months <u>10</u> Days <u>16</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>16</u> Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Greeley</u>		14. MOTHER'S MAIDEN NAME <u>Marilyn P. Cheek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>Father</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Interstitial Pneumonia, severe, hemorrhagic</u> 525X DUE TO (b) <u>Severe acute cerebral edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Severe acute cerebral edema</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe acute cerebral edema</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1/15/61</u> 19 <u>61</u> to <u>1/16/61</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/15/</u> 19 <u>61</u> , and that death occurred at <u>5:50 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Winston E. Cochran M.D.</u>		22b. DATE <u>1/16/61</u> SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WINSTON E. COCHRAN</u>		22d. ADDRESS <u>927 Pershing Dr., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner E. Pummery INC.</u>		25a. REC'D BY REGISTRAR <u>JAN 25 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. ADDRESS <u>SILVER SPRING, MD.</u>	

2075192XV5



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

334 CERTIFICATE OF DEATH

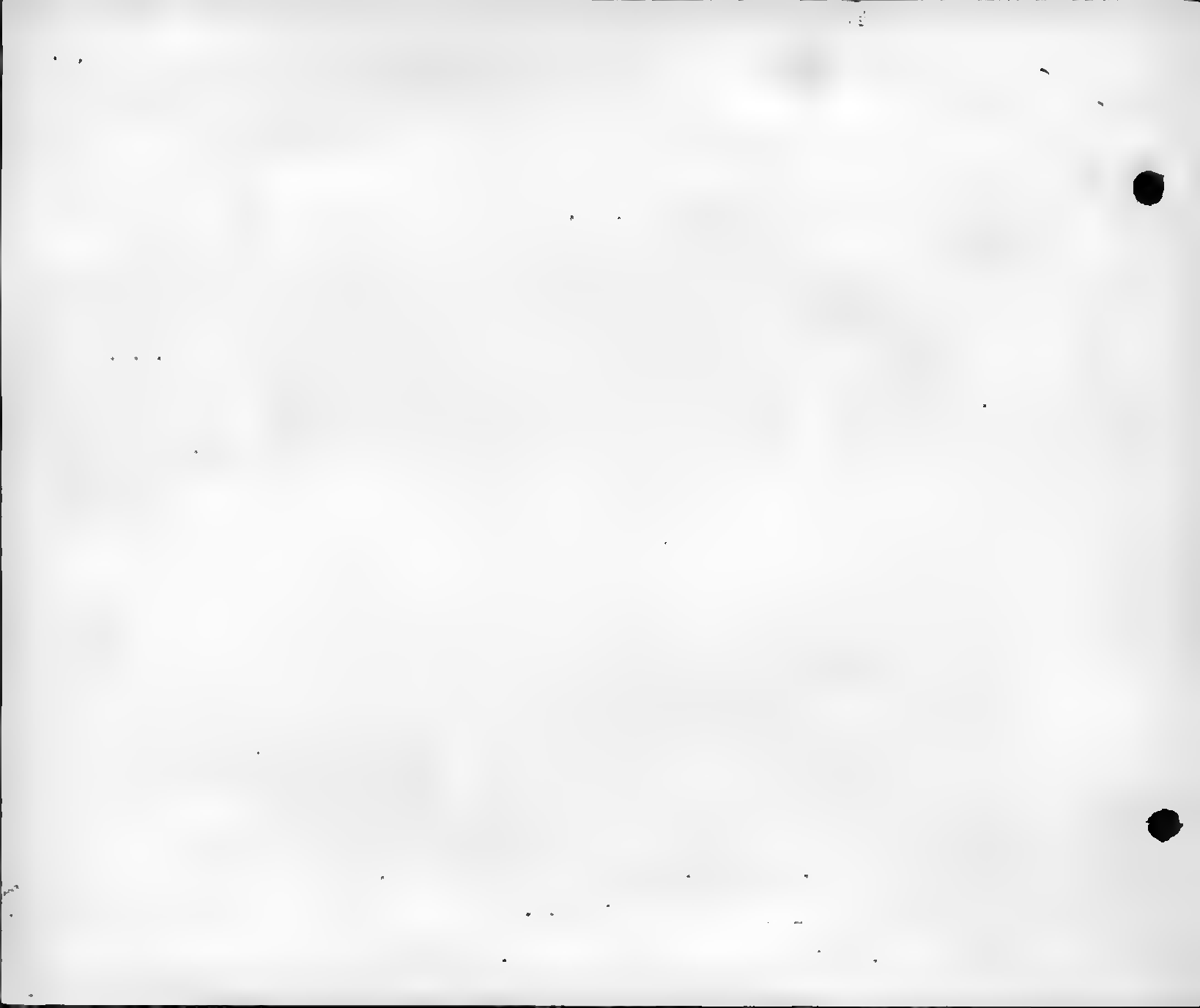
Reg. Dist. No.

00827

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 33 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE North Carolina b. COUNTY Raleigh c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 704-2 d. STREET ADDRESS 2709 Saint Mary's Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jane Middle Ellen Last Hamlin		4. DATE OF DEATH Month January Day 8 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1951
9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR Months 8 Days 19 Hours 61 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. Fred Hamlin		14. MOTHER'S MAIDEN NAME Mary Katherine Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and lung abscess 557.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cystic fibrosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Life INTERVAL BETWEEN ONSET AND DEATH 2 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 6, 1960 to January 8, 1961 , that I last saw the deceased alive on January 8, 1961 , and that death occurred at 4:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/8/61 ACTUAL SIGNATURE William O. Jones M.D. National Institutes of Health PHYSICIAN'S NAME (Type) WILLIAM O. JONES, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial-transit 1-9-61		Montlawn Mem. Park	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Raleigh, North Carolina		Raleigh, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR JAN 16 61		24b. REGISTRAR'S SIGNATURE Charles E. Thomas	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

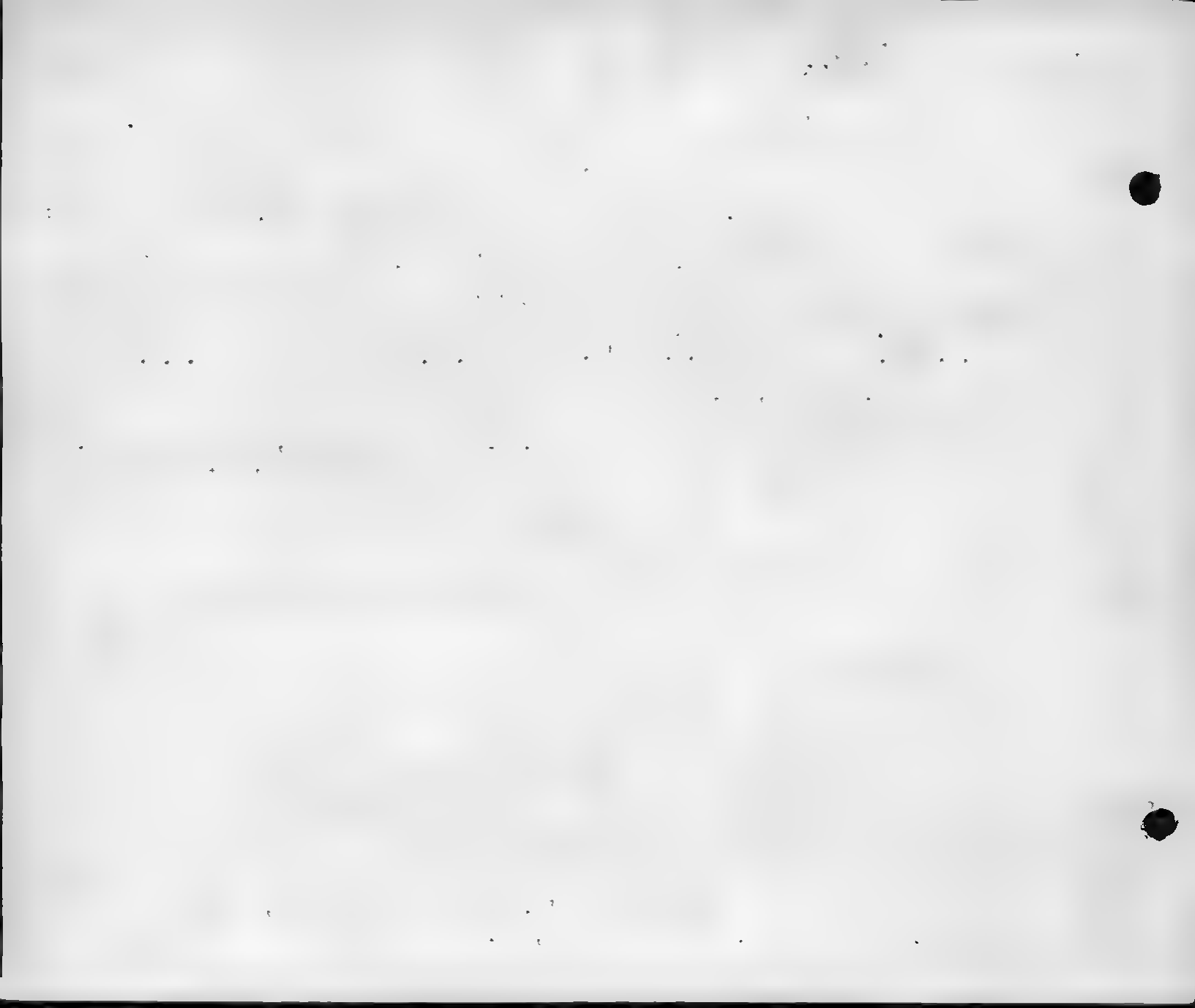
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/5

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
835 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
6828											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>											
c. LENGTH OF STAY IN 1b <u>3 yrs.</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3108 Parker Ave.</u>											
2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>											
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>											
d. STREET ADDRESS <u>3108 Parker Ave.</u>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Theodore T. Hanford, Jr.</u>											
4. DATE OF DEATH <u>1 27 19 61</u>											
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>12/9/11</u>											
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>49</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.											
10. USUAL OCCUPATION (Give kind of work done during most of working life) <u>U.S. Gov. Coast & Geodetic Survey</u>											
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>											
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Theodore T. Hanford, Sr.</u>											
14. MOTHER'S MAIDEN NAME <u>Eva Miller</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW # 2</u>											
16. SOCIAL SECURITY NO. <u>yes</u>											
17. INFORMANT <u>Mrs. C. Virginia Hanford, 3108 Parker Ave. Silver Spring, Md.</u> Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fat embolism</u> <u>581.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hepatic Fatty metamorphosis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county) <u>1 - 27 - 61</u>											
DATE SIGNED											
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.											
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>											
22b. DATE THEREOF <u>1/31/61</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>											
22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>											
23. FUNERAL DIRECTOR <u>WALTER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>											
24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>											
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>											
DATE <u>FEB 3 '61</u>											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

836

00829

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shawcross Park</u> c. LENGTH OF STAY IN b. <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wolke San</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>14004 Weyford</u>	
3. NAME OF DECEASED (Type or print) First <u>Yakov</u> Middle <u>ANN</u> Last <u>HANKIN</u>		4. DATE OF DEATH Year <u>1961</u> Month <u>Jan</u> Day <u>17</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-17-81</u>	
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laund</u>	
13. FATHER'S NAME <u>ISAAC HANKIN</u>		14. MOTHER'S MAIDEN NAME <u>Ann Hankin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Edgar Hankin</u>		18. ADDRESS <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> (b) <u>Obstructed left ventricle</u> (c) <u>constriction of rectum</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u> </u>		20f. (City or town) <u> </u>	
20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from January 2, 1961, to January 17, 1961, that (I) (we) last saw the deceased alive on January 17, 1961, and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur J. Willets</u>		22b. DATE SIGNED <u>Jan 19 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILLETS</u>		22d. ADDRESS <u>909 Pershing Dr. Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 19 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baron Hersh Cemetery</u>		23d. LOCATION (City, town or county) <u>Staten Island, New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Willets</u>		25. REC'D BY REGISTRAR <u> </u>	
25a. ADDRESS <u>254 Barclay St. N.Y.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

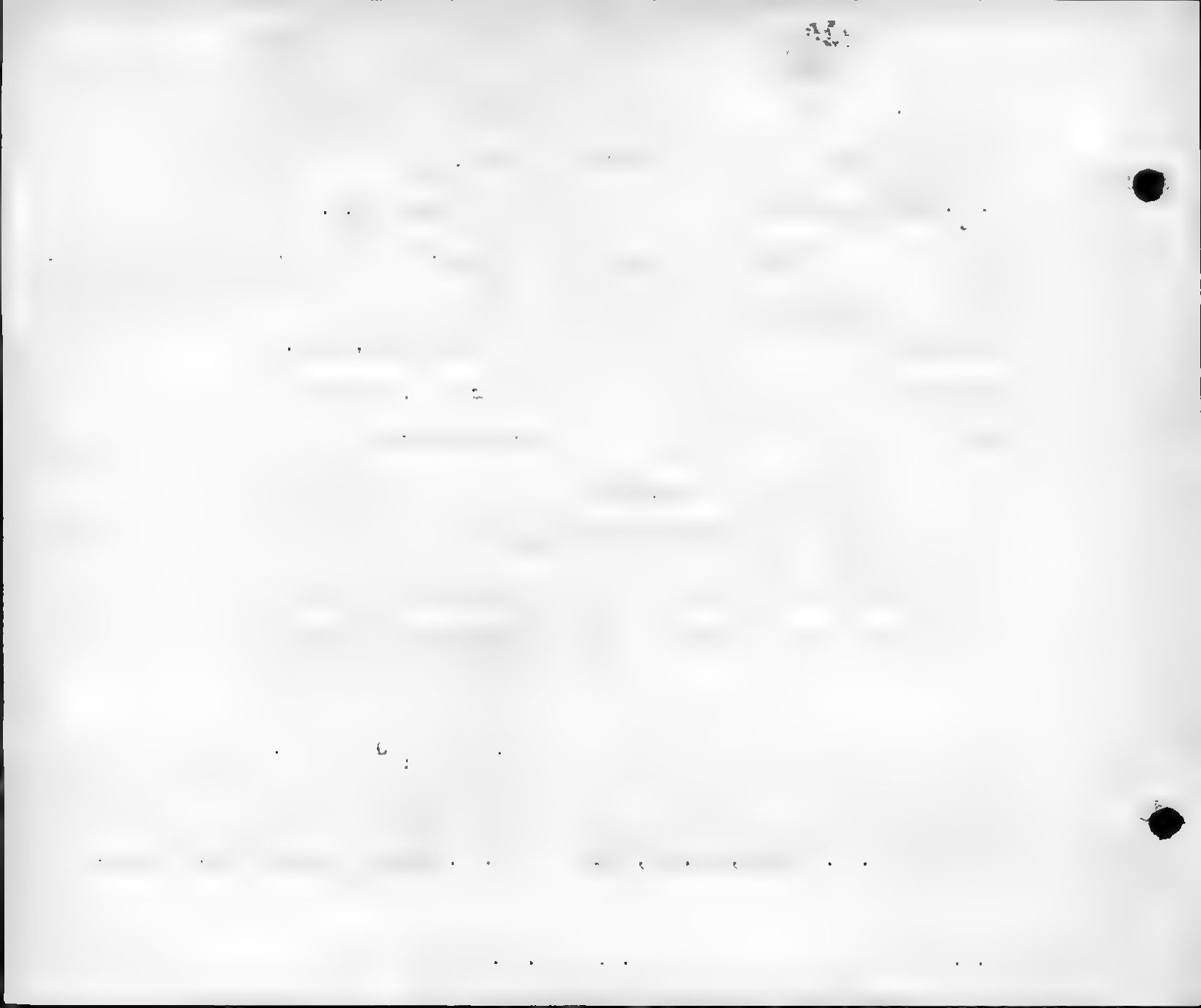
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

837

CERTIFICATE OF DEATH

60830

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 37 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived (If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 723 7th St., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Thelma Mildred HARKINS				4. DATE OF DEATH Month Day Year January 21 1961											
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-3-21		9. AGE (In years last birthday) 39 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert WYNN				14. MOTHER'S MAIDEN NAME Bertha F. TAYLOR											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial asthma, chronic DUE TO (c) Mitral and aortic valvulitis, old, undetermined etiology												INTERVAL BETWEEN ONSET AND DEATH 30 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that U (this hospital) attended the deceased from Dec. 15 1960 to Jan. 21 1961 , that X (we) last saw the deceased alive on Jan. 21 1961 , and that death occurred at 11:55AM from the causes and on the date stated above.															
22a. SIGNATURE D. L. KELLEY, LT, MC, USN				M. D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22b. DATE SIGNED 1-21-61							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-26-61				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town, or county) (State) Suitland Road, P.G.Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS				ADDRESS 517 11th. ST. S.E. WASH, DC.				25a. REC'D BY REGISTRAR DATE JAN 25 '61				25b. REGISTRAR'S SIGNATURE Arthur S. House			

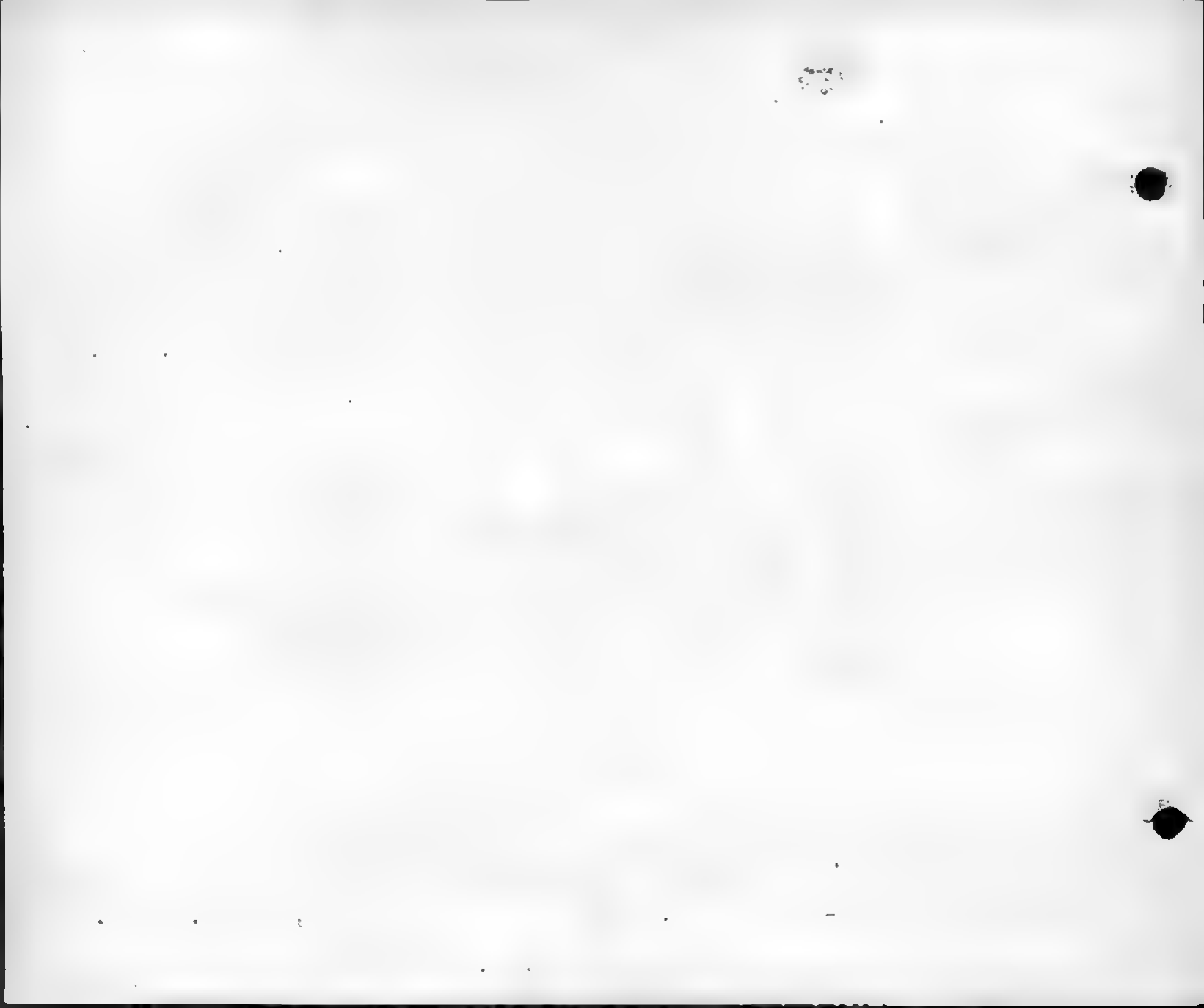


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

838

60851

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CAROLYN Howard HARVEY				4. DATE OF DEATH Month Day Year JANUARY 10 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/3/1900	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY Teaching		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME HENRY HOWARD				14. MOTHER'S MAIDEN NAME MARY FLORENCE JONES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO to metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Oct 1959 to Jan 1961 , that (I) (we) last saw the deceased alive on Jan 10 1961 , and that death occurred at 4:45 M. from the causes and on the date stated above							
22a. SIGNATURE A. D. Bonifant M.D.				22b. DATE SIGNED 1961			
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.				22d. ADDRESS SANDY SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-13-60		23c. NAME OF CEMETERY OR CREMATORY St. John's		23d. LOCATION (City, town, or county) (State) Olney, Mont. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Barber				25a. REC'D BY REGISTRAR DATE JAN 13 '61		25b. REGISTRAR'S SIGNATURE William S. Kraus	



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
839
CERTIFICATE OF DEATH

68832

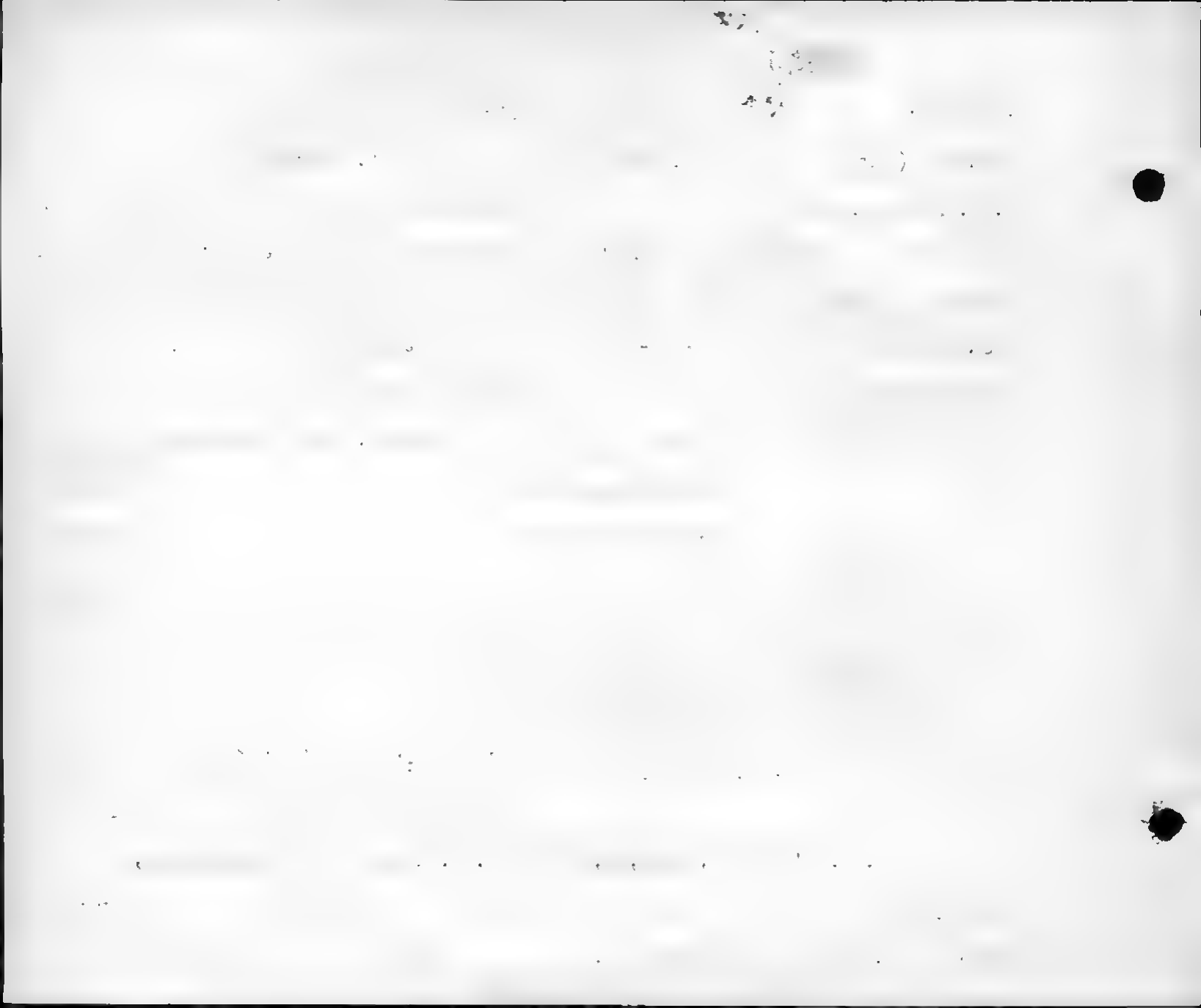
1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 20 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY Country Hills, Fairfax c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) 207 Andover Drive d. STREET ADDRESS 207 Andover Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle Marie Last HAWKES				4. DATE OF DEATH Month January Day 8 Year 19 61			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-18-10	
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Dennis BARRY				14. MOTHER'S MAIDEN NAME Margaret RICE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (H) Wm. M. Hawkes, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency 581.0 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of liver DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (he) (this hospital) attended the deceased from Dec. 19 19 60 to Jan. 8 19 61 that (he) (we) lost saw the deceased alive on Jan. 8 19 61 , and that death occurred at 2:40AM from the causes and on the date stated above.							
22a. SIGNATURE F. H. O'Connell		22b. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, ICDR, MC, USN		22c. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22d. DATE SIGNED 1-8-61	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 1-13-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Pumphrey Funeral Home		24. ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR 10 0 '61		25b. REGISTRAR'S SIGNATURE Arthur E. King	

MEDICAL CERTIFICATE

2

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



840

CERTIFICATE OF DEATH

Reg. Dist. No

60855

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>West Home</u>				d. STREET ADDRESS <u>3303 Thornapple Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANCY KENNEDY HEAP</u>				4. DATE OF DEATH Month Day Year <u>January 15, 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/13/1375</u>	9. AGE (In years last birthday) <u>85</u> yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Peter Kennedy</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Hazelett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Earl N. Heap, Jr. Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis.</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis.</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 + days</u> <u>2 + yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture R. thigh 24 Dec 60.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I. Part II of item 18) <u>Fell reaching over chair</u>					
20c. TIME OF INJURY Month Day Year <u>6-DEC-24-60</u> Hour <u>10</u> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Potomac Mont. Md.</u>	
21. I certify that I attended the deceased from <u>1958</u> to <u>15 JAN 1961</u> that I last saw the deceased alive on <u>14 Jan 1961</u> and that death occurred at <u>11:20 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. H. Ricnwine</u> M.D.				ADDRESS (Street, city or town, state) <u>5522 Western Ave.,</u> DATE SIGNED <u>1/15/61</u>			
PHYSICIAN'S NAME (Type) <u>A. H. Ricnwine - 5522 Western Ave. Chevy Chase, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> <u>1331 E. Montgomery Ave. Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

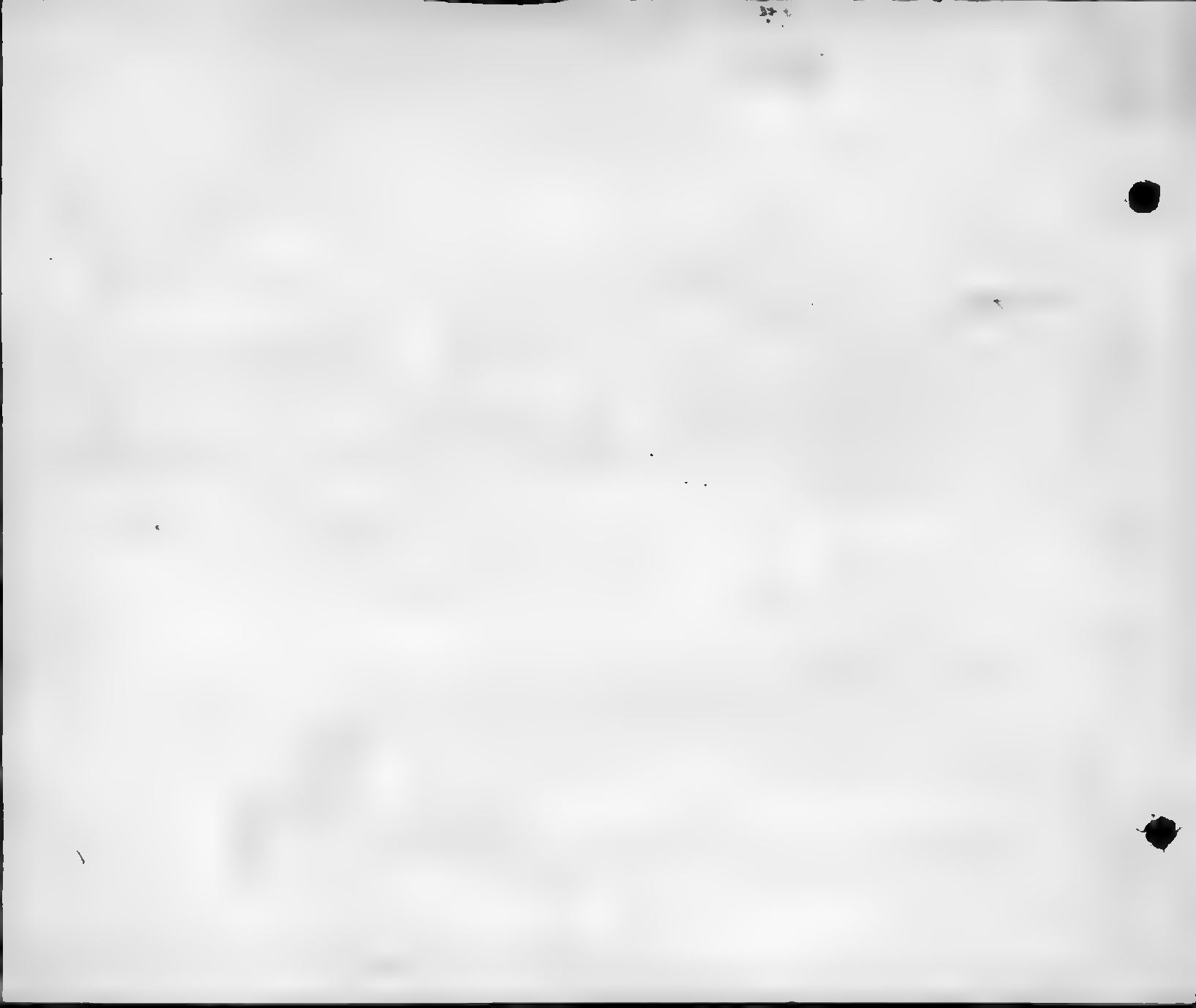
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MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

841 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60834

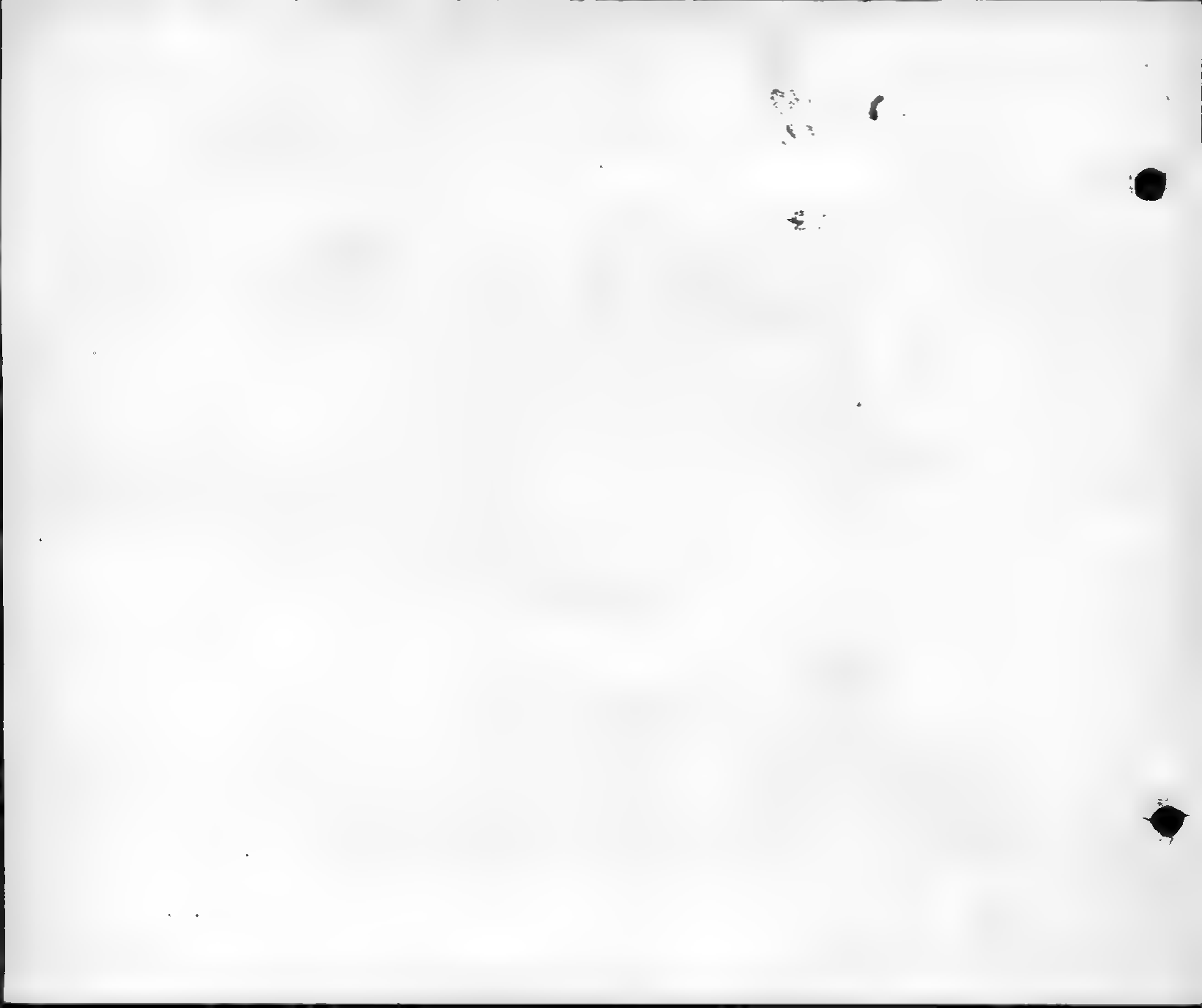
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not in one; Residence before admission) e. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> S.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sukurban</u>		d. STREET ADDRESS <u>1 Sugarland Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Augusta Hebron</u>		4. DATE OF DEATH Month Day Year <u>Jan. 20 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carter's 52nd Ave</u>	9. AGE (In years last birthday) <u>57</u> yrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Hebron</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-16-2023</u>	
17. INFORMANT <u>Ada Hebron / same as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Myocardial Insufficiency</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Arteriosclerosis</u> DUE TO <u>Sudden</u> (c) <u>unk near</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>1100/61</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-25-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>	22d. LOCATION (City, town, or county) (State) <u>Sugarland, Md.</u>
23. FUNERAL DIRECTOR <u>Robert L. Surden</u>		24. REC'D BY REGISTRAR <u>Rockville, Md.</u>	
		24b. REGISTRAR'S SIGNATURE <u>Cecilia L. Kenna</u>	



1
 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 842
 CERTIFICATE OF DEATH
 00883

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 22 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ROCKVILLE			
				d. STREET ADDRESS 1 16 WILLIAM STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last NELLE P. HELPHENSTINE				4. DATE OF DEATH Month Day Year JANUARY 12 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/19/1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) GEORGIA				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JOSEPH J. PRINTUP				14. MOTHER'S MAIDEN NAME LURA T. HOSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT HOSPITAL RECORDS,				Address OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease - Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH 2 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D.C.				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1960 , to Jan. 12, 1961 , that (I) (we) last saw the deceased alive on Jan. 12, 1961 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W. A. Linthicum, M.D.				22b. DATE SIGNED 1/12/61		22c. PHYSICIAN'S NAME (Type) W. A. LINTHICUM, M. D.	
22d. ADDRESS GAITHERSBURG, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/12/61		23c. NAME OF CEMETERY OR CREMATORY Glenwood		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Tison Wheeler Funeral Home				25a. REC'D BY REGISTRAR DATE JAN 16 '61		25b. REGISTRAR'S SIGNATURE Carlton S. House	

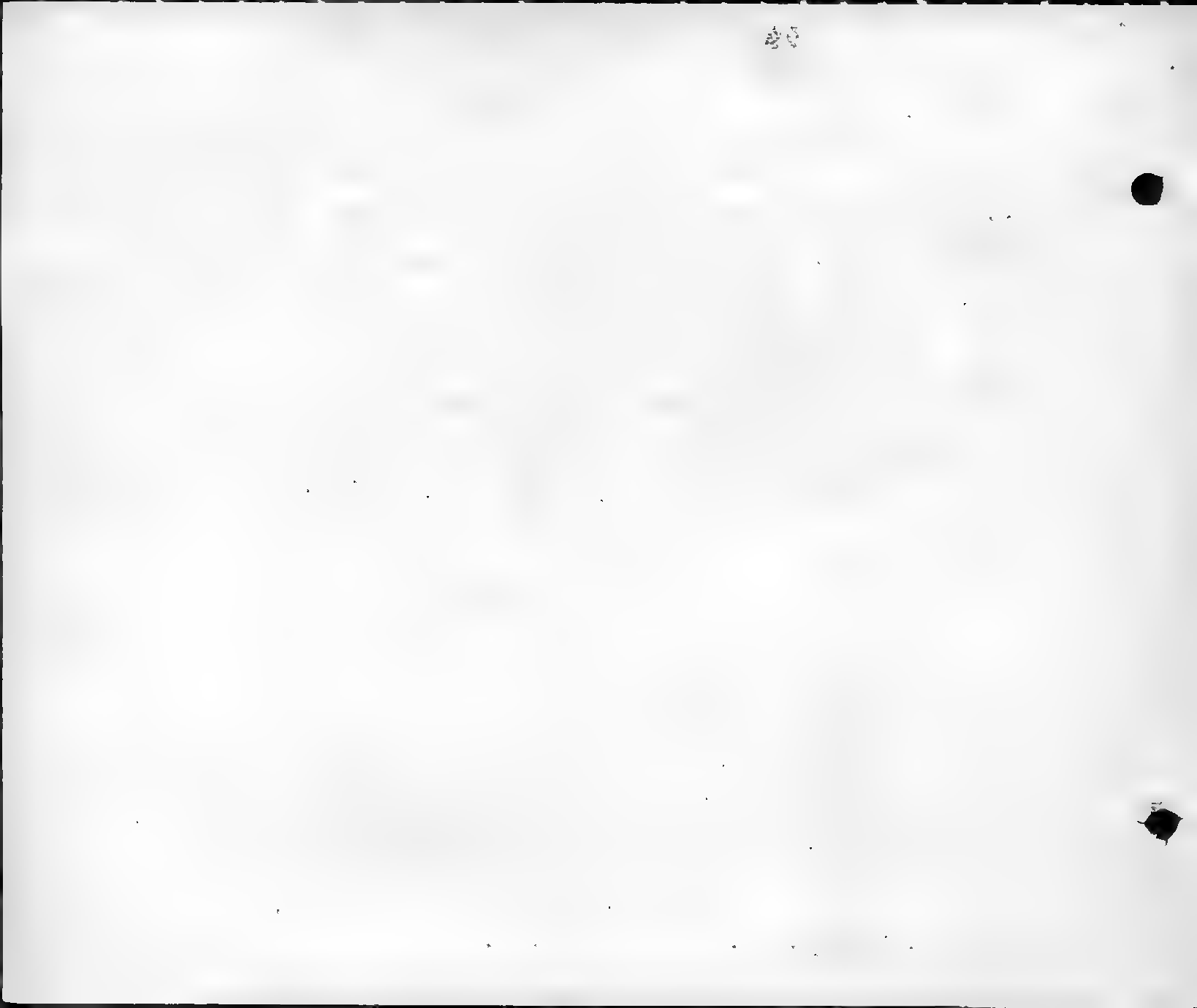


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843
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>711 Wayne Ave 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Elizabeth Hennessy</u>				4. DATE OF DEATH Month Day Year <u>Jan 1 1961</u>			
5 SEX <u>Fe</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-76</u>	9 AGE (in years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Robert Mc Adams</u>				14. MOTHER'S MAIDEN NAME <u>Mary Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442 Cardiac Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension</u> DUE TO (c) <u>Long standing arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>Many years</u> <u>" "</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1960</u> to <u>Jan 1 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 31 1960</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Merrill M. Cross</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>1/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>				22d. ADDRESS <u>8248 Rockway Lane Silver Spring, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WERNER E. POMPHREY, INC. Raymond A. Giska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>			

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



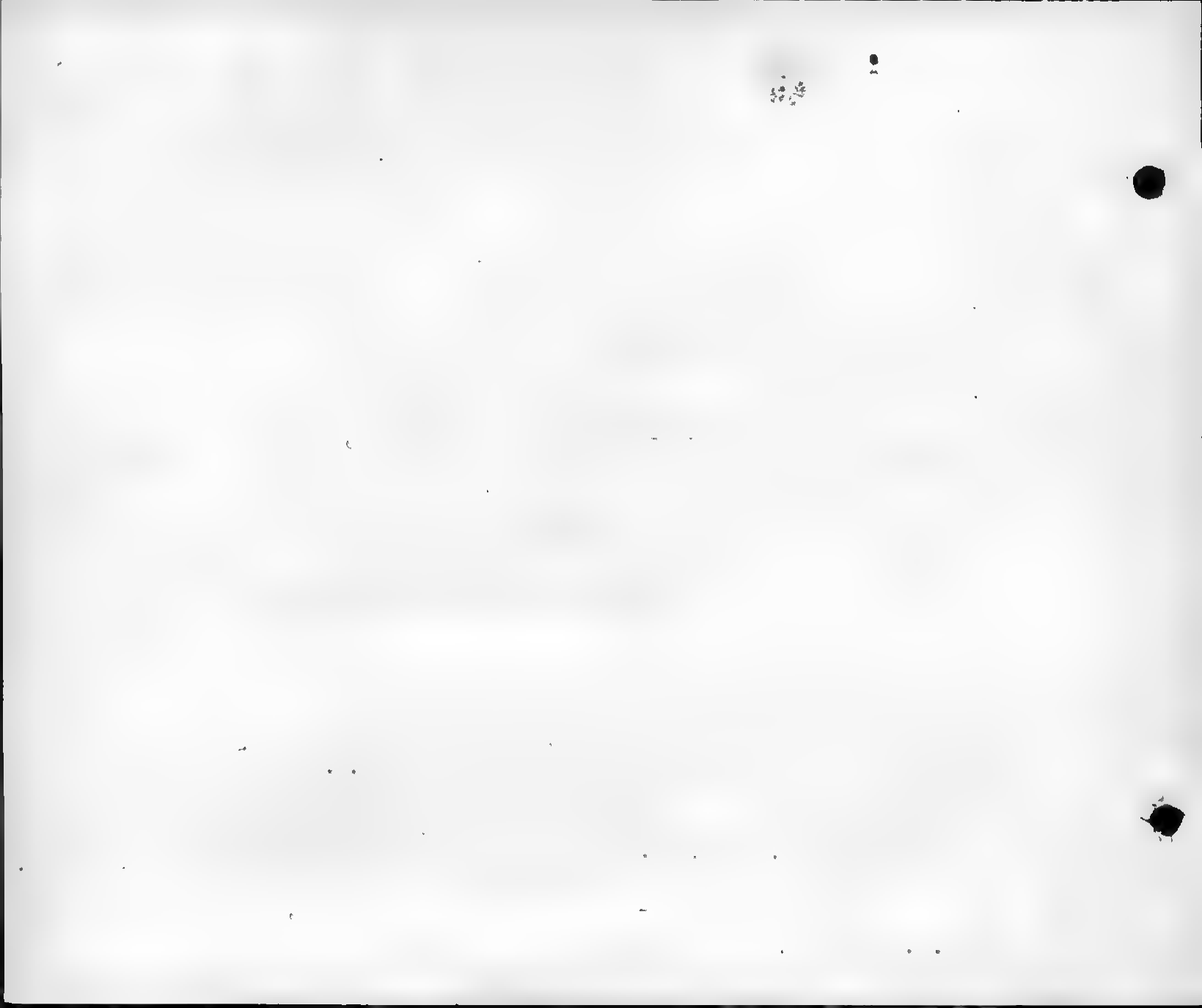
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

344
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60857

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Kentucky b. COUNTY Wallins Creek	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 19 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS Box 335	
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence (none) Hensley		4. DATE OF DEATH Month Day Year January 27, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15, 1922
9. AGE (in years lost birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joe Hensley		14. MOTHER'S MAIDEN NAME Addie Pope	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 400-26-0126	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gram Negative Septicemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Necrotizing Proctitis DUE TO (c) Acute Lymphocytic Leukemia		INTERVAL BETWEEN ONSET AND DEATH Hours Weeks 1 1/2 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Harlan, Kentucky (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from January 8, 1961 to January 27, 1961 , that (I) (we) last saw the deceased alive on January 27, 1961 , and that death occurred at 8:25 a.m. from the causes and on the date stated above.		
22a. SIGNATURE Edward E. Morse M.D.		22b. DATE SIGNED 1/28/61
22c. PHYSICIAN'S NAME (Type) EDWARD E. MORSE, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 1/28/61	23c. NAME OF CEMETERY OR CREMATORY --
23d. LOCATION (City, town, or county) Harlan, Kentucky (State)		
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.		25a. REC'D BY REGISTRAR JAN 30 61 DATE
25b. REGISTRAR'S SIGNATURE C. H. Hines		



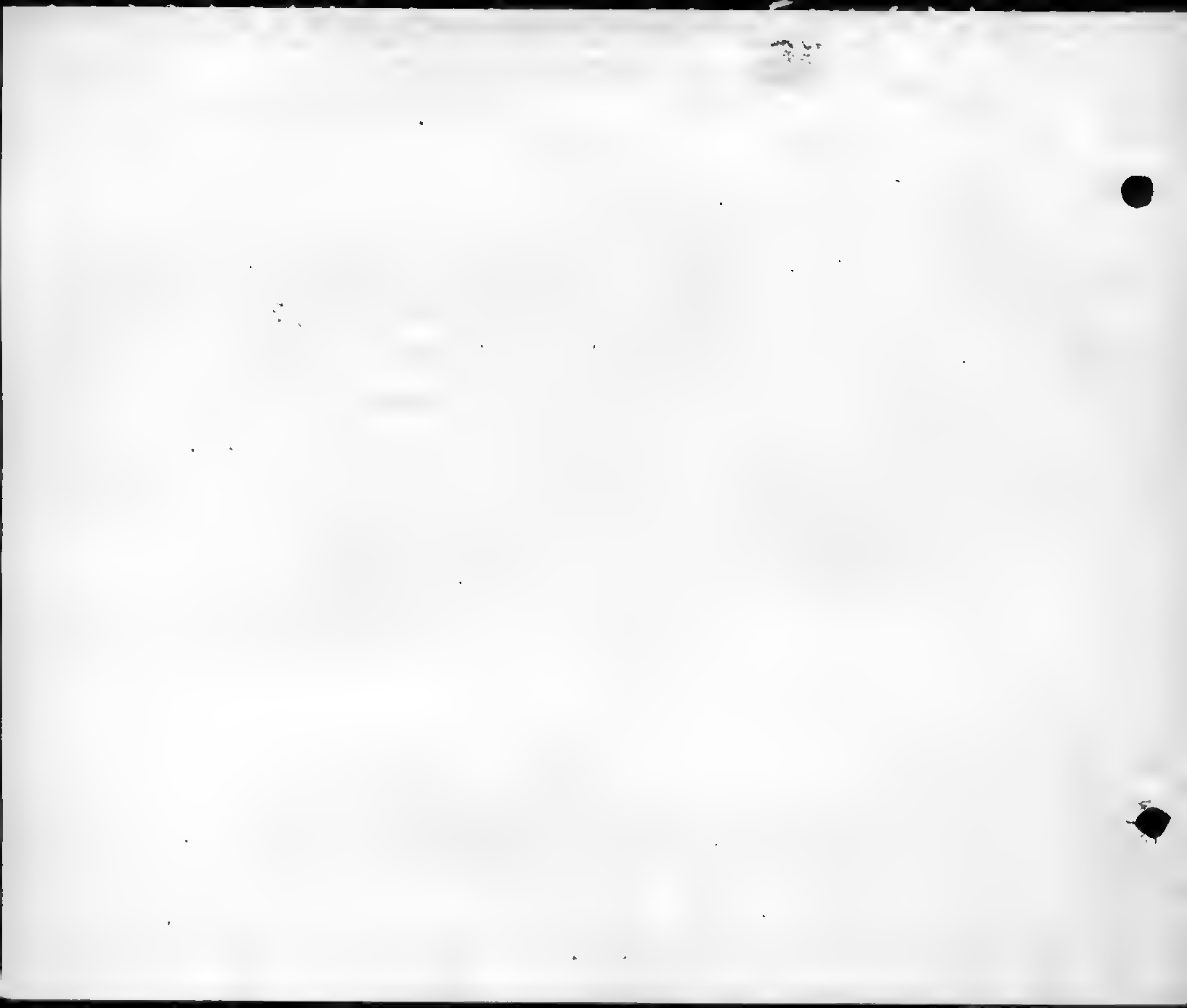
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

845

CG883

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLMAR MANOR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Jeannette</u> Last <u>Hill</u>				4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 Oct 1889</u>	9. AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John W. HANES</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Harry Hill</u>				Address <u>Colmar Manor, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: <u>464X</u> IMMEDIATE CAUSE (a) <u>Thrombophlebitis</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/7</u> 19 <u>61</u> to <u>1/8</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> 19 <u>61</u> , and that death occurred at <u>2</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald Nelson</u>				22b. DATE SIGNED <u>1/8/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>				22d. ADDRESS <u>10620 Georgia Ave, Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REG STRAR DATE <u>JAN 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>				25c. DATE <u> </u>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

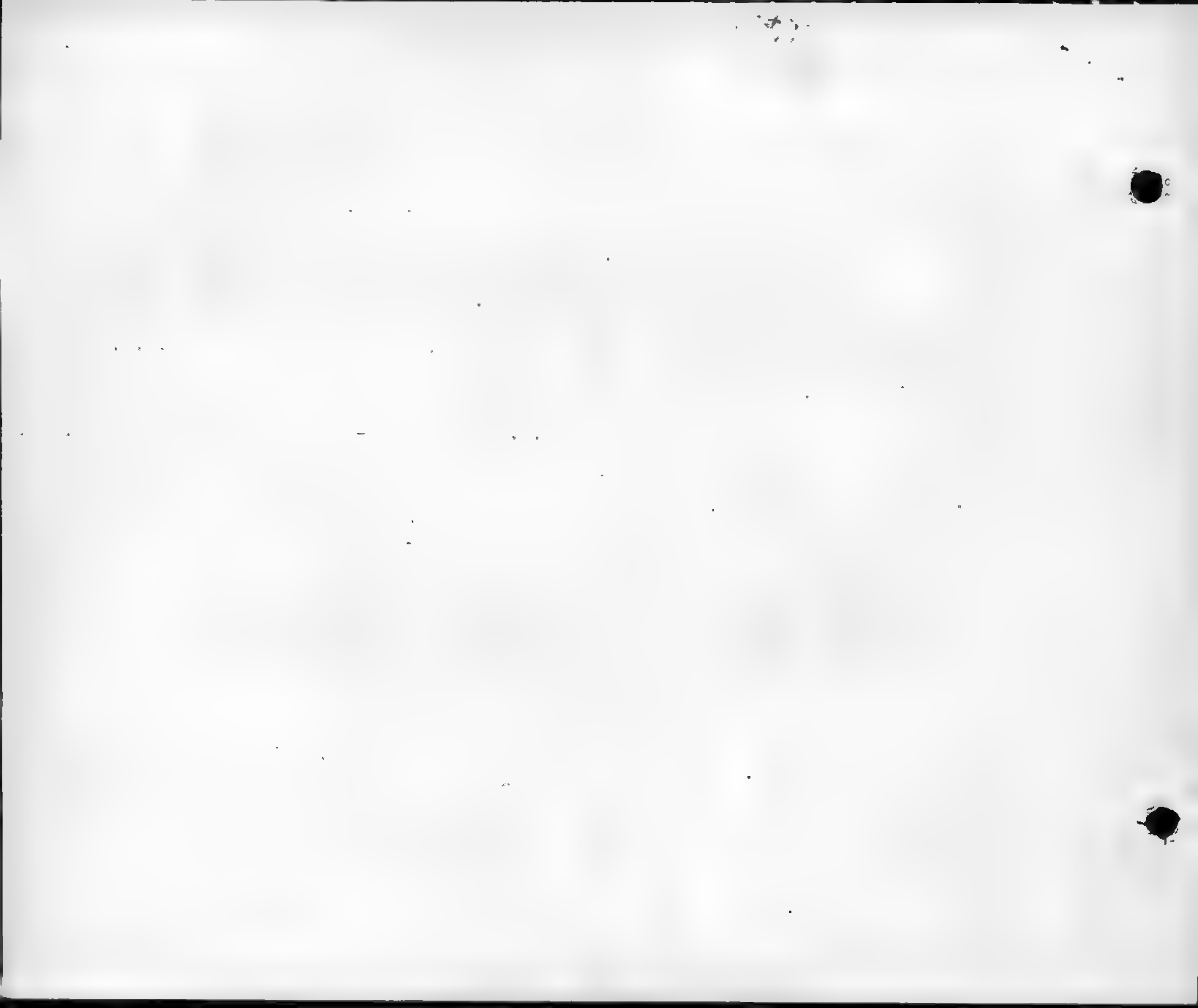
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846

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00839

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Penna. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frackville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 13 N. 5th. Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Hinkel				4. DATE OF DEATH Month January Day 20 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1893		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard L. Bevan				14. MOTHER'S MAIDEN NAME Ella Thursby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT J.B. Robertson - Valley Drive, Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage DUE TO (b) Essential Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 18, 1961 to Jan 20, 1961 , that (I) was last saw the deceased alive on Jan. 19, 1960 , and that death occurred at 8:30 AM , from the causes and on the date stated above							
22a. SIGNATURE William Frank				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WILLIAM FRANK, M.D.				22d. ADDRESS 544 W. MONTGOMERY AVE. ROCKVILLE			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1-24-61		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City, town, or county) (State) Frackville, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Humphrey				25a. REC'D BY REGISTRAR Jan 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

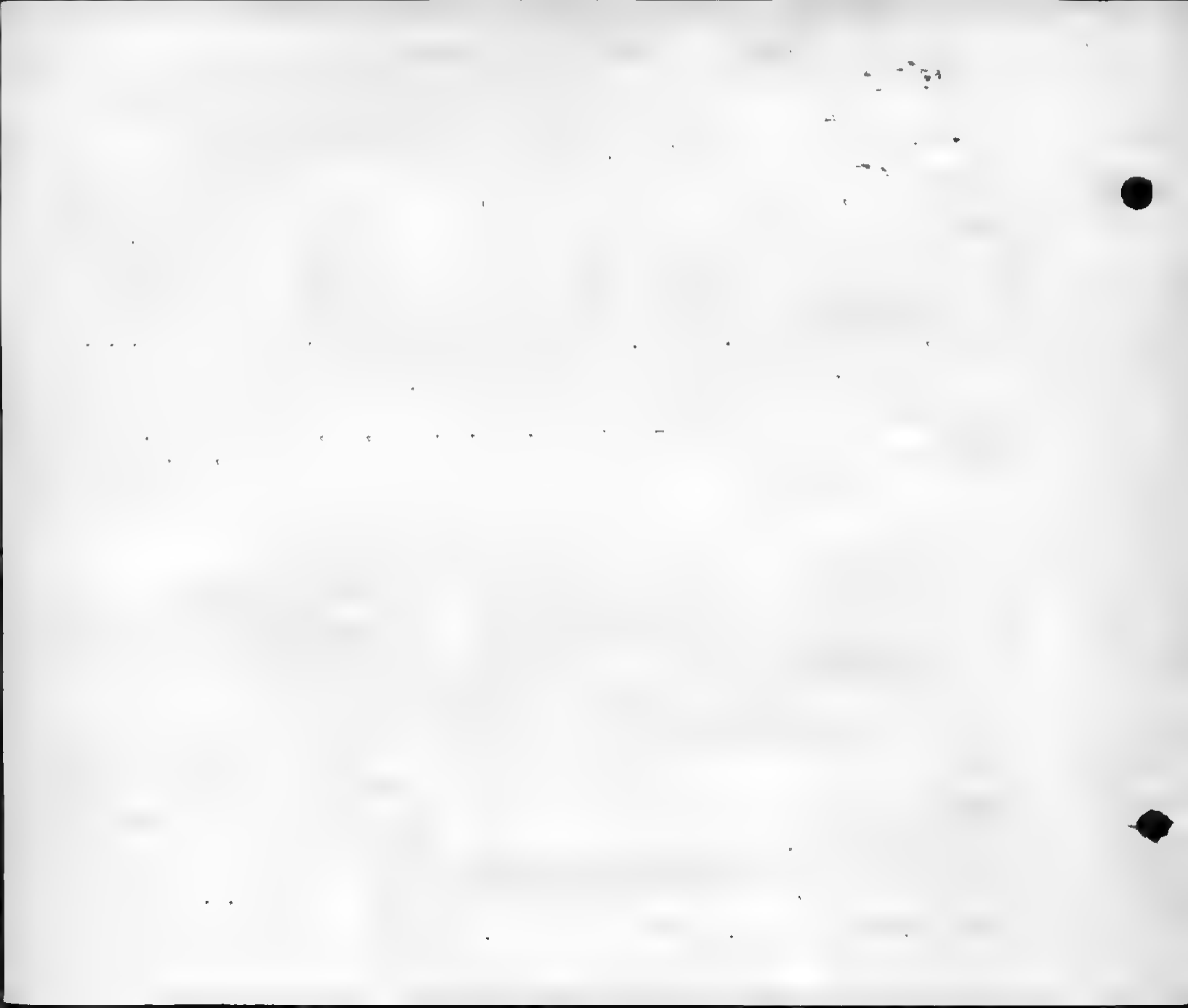
347

CERTIFICATE OF DEATH

Reg. Dist. No.

60840

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			
c. LENGTH OF STAY IN 1b 7 yrs.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13,402 KEATING STREET				d. STREET ADDRESS 13,402 KEATING STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Emma LEE Hoffman				4. DATE OF DEATH Month Day Year January 27 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/18/82	
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Accounting Dept.		11. BIRTHPLACE (State or foreign country) Louisa County, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN WILLIAM WOOLFOLK		14. MOTHER'S MAIDEN NAME MARTHA A. BIBB			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 518-12-4316-A		17. INFORMANT Mrs. Geo. L. Ronk, 13,402 Keating St.		Address Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 463x Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebo-Thrombosis in calves (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 20 min 6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Infarcts 3-4 times previously				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to 27 Jan, 1961, that I last saw the deceased alive on 25 Jan, 1961, and that death occurred at 8:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Merton L. White M. D. 11134 Georgia Ave Ashl 27 Jan 61 PHYSICIAN'S NAME (Type) MERTON L. WHITE							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/30/61		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
24c. ADDRESS SILVER SPRING, MD.				DATE JAN 31 '61			



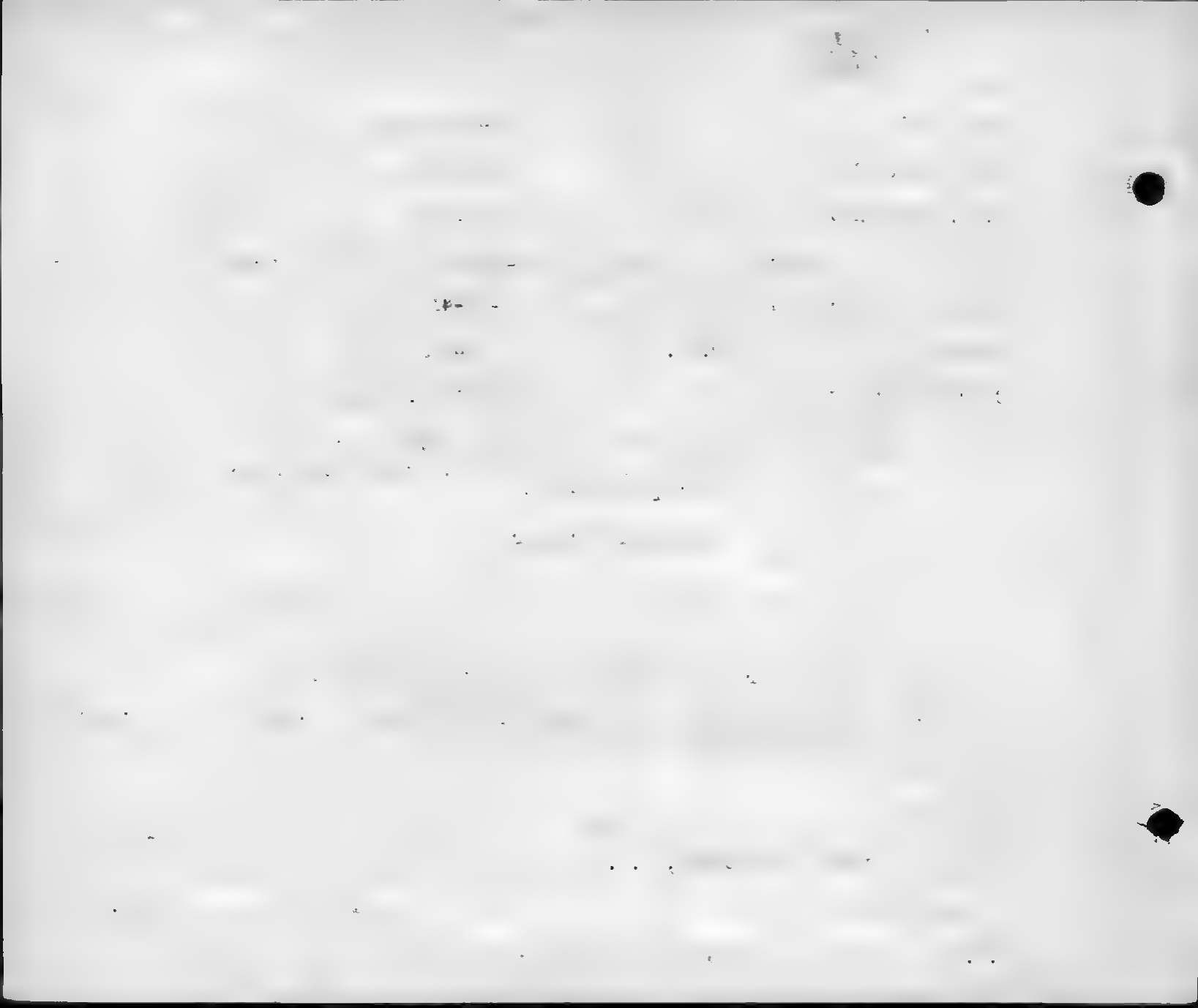
DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any de-
place execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT
M

MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
848 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60841

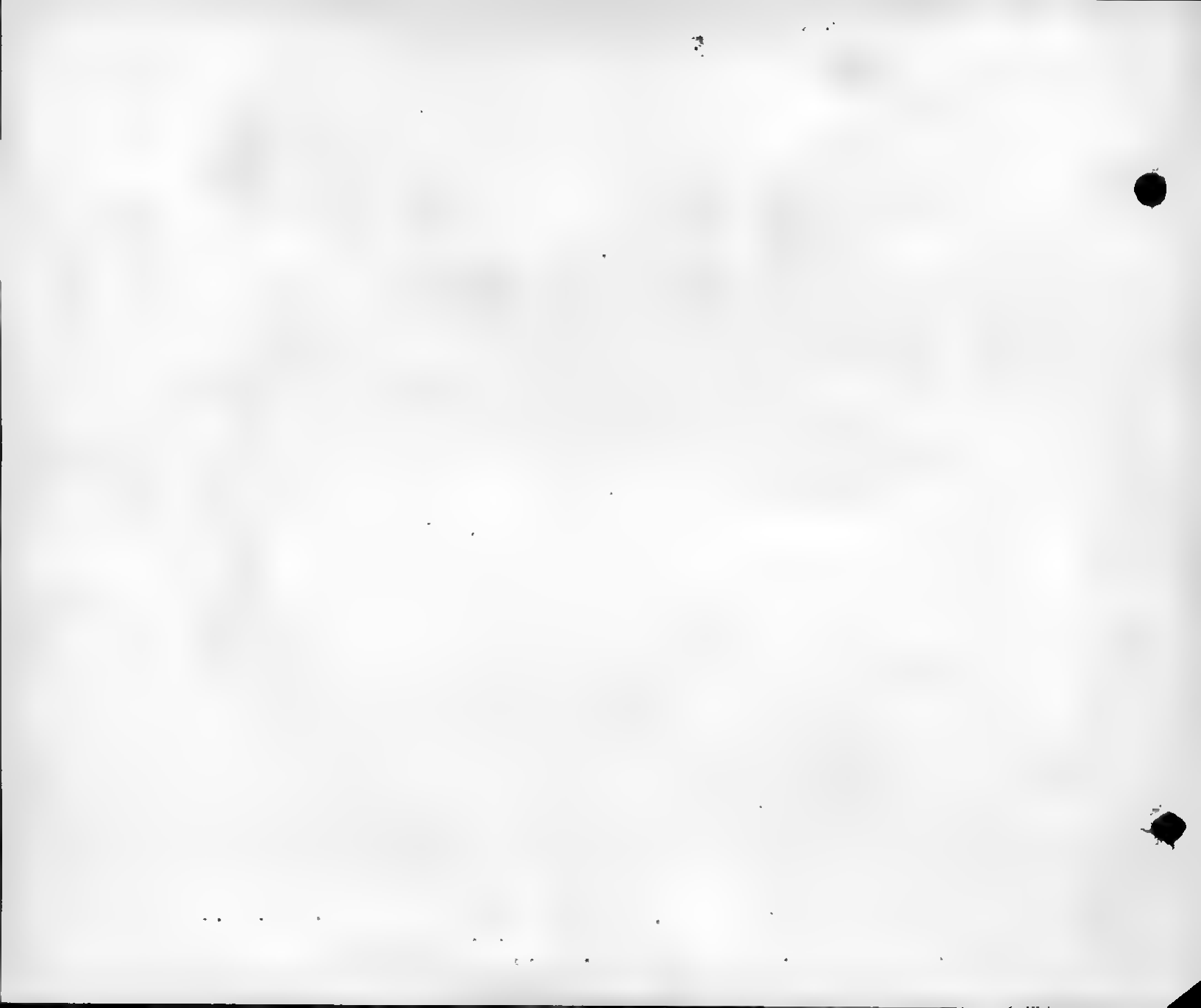
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Lititz	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lititz	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 24 S. Ally	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Rodney HORNBERGER		4. DATE OF DEATH Month Day Year January 26 19 61	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-29-41	
9. AGE (in years last birthday) 19 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Hornberger		14. MOTHER'S MAIDEN NAME Doris H. Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 7/59 to DOD		16. SOCIAL SECURITY NO. 173 32 0447	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH (Enter only one cause; specify for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812X DUE TO Laceration and contusion, brain with intra-cranial hemorrhage Conditions, if any, which gave rise to immediate cause (b) Basal skull fracture DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Struck by AB&W Bus while crossing street		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by AB&W Bus while crossing street	
20c. TIME OF INJURY Month, Day, Year 1005 p.m. 1-23 19 61		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street-Columbia Pike		20f. (City or town) (County) (State) Arlington Virginia	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. BROSCART, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-26-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 1-27-61	
22c. NAME OF CEMETERY OR CREMATORY WashDC		22d. LOCATION (City, town, or county) (State) Lititz Penna.	
23. FUNERAL DIRECTOR W.W. Chambers Funeral Home, 1400 Chapin St. NW		24a. REC'D BY REGISTRAR JAN 30 '61	
ADDRESS WashDC		24b. REGISTRAR'S SIGNATURE Arthur S. Kins	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
849
CERTIFICATE OF DEATH
00842

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Colesville Road Marilea Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Anna Middle D. Last Horton		4. DATE OF DEATH Month Jan Day 10 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?
9. AGE (In years lost birthday) 100 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO - -	
17. INFORMANT Nursing Home records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 14, 1956 to Jan 10, 1961 , that (I) (we) last saw the deceased alive on Jan 9, 1961 , and that death occurred 8 PM , from the causes and on the date stated above			
22a. SIGNATURE John S. Rogers MD		22b. ADDRESS 1919 Seminary Rd, Silver Spring, Md	
22c. PHYSICIAN'S NAME (Type) John S. Rogers		22d. ADDRESS 1919 Seminary Rd, Silver Spring, Md	
23a. BURIAL CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 1/10/61	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W., Wash, D.C.		25a. REC'D BY REGISTRAR JAN 11 '61	
25b. REGISTRAR'S SIGNATURE Critter S. Hines			



850

CERTIFICATE OF DEATH

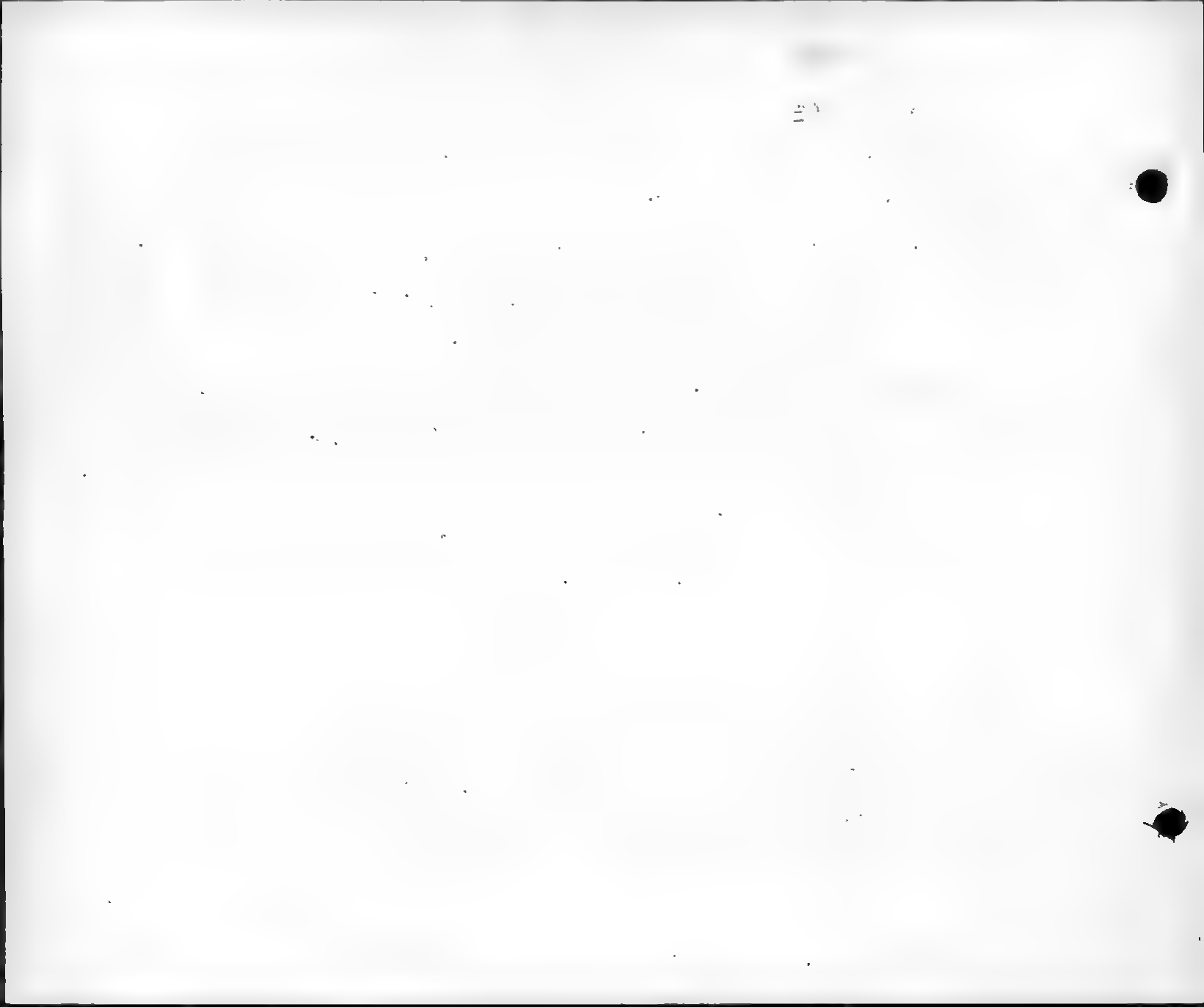
Reg. Dist. No.

00843

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY IN 1b <u>4 Yrs</u>		d. STREET ADDRESS <u>3701 Mass. Ave. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverley Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>S.</u> Middle <u>Hoskinson</u> Last		4. DATE OF DEATH Month <u>Jan</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-3-1879</u>
9. AGE (In years last birthday) <u>81</u> yn.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JAMES MONROE Farmer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dora BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>LOUIS P. ALLWINE</u> Address <u>Waverley Sanit.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 332X DUE TO <u>Cerebral Thrombosis & Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis & Hypertension</u> DUE TO (c) <u>years?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 1954, to <u>Jan 8</u> , 1961, that I last saw the deceased alive on <u>Jan 7</u> , 1960, and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil P. Campbell</u>		ADDRESS (Street, city or town, state) <u>General Apt Wash DC</u> DATED <u>1/8/61</u>	
PHYSICIAN'S NAME (Type) <u>Neil P. Campbell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK Hill</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sewlers Sons, WASH., D.C.</u> ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 10 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

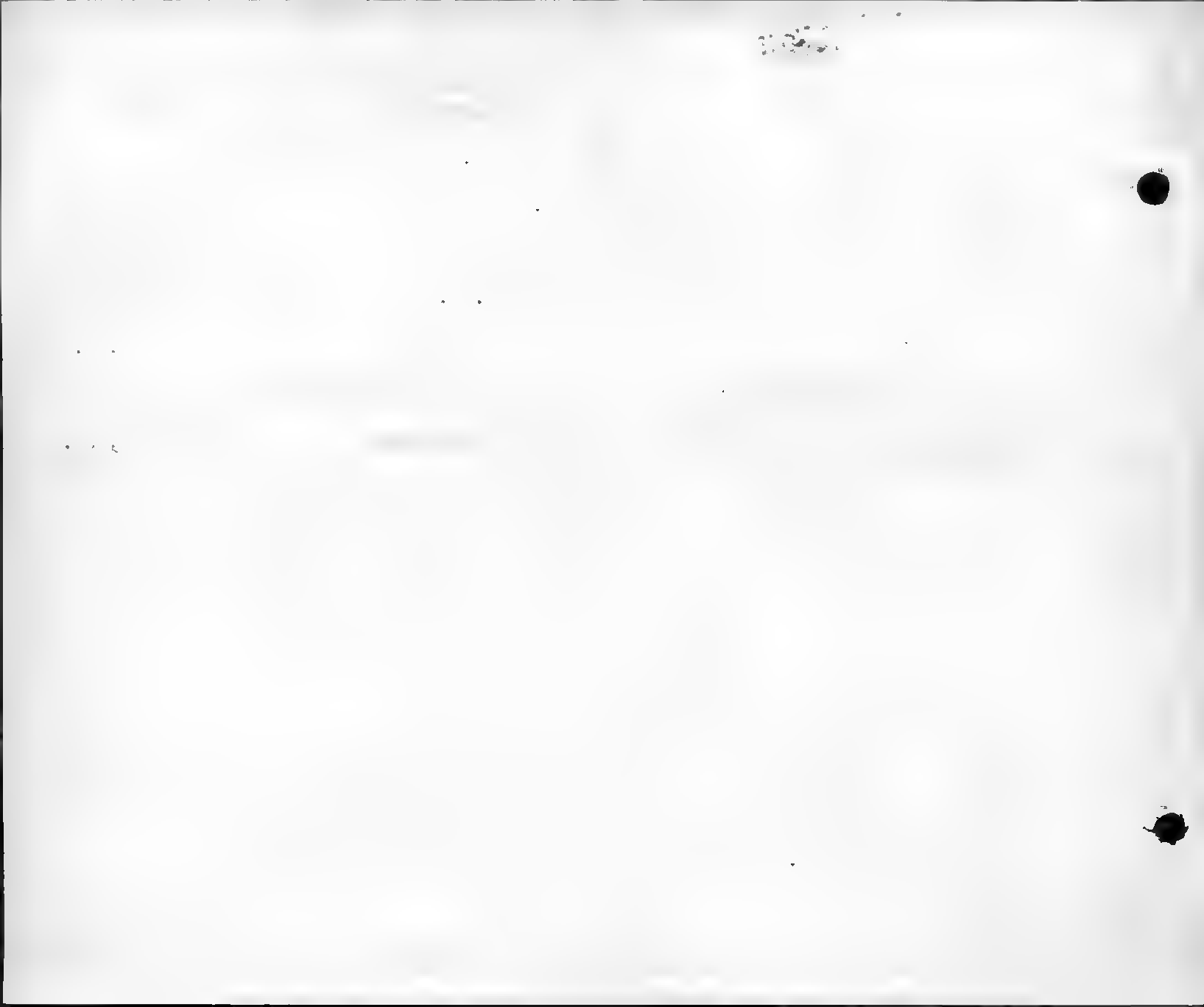
851

CERTIFICATE OF DEATH

Reg. Dist. No. 00824

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Res'dence before admision) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.				d. STREET ADDRESS 10 K-2			
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Houck				4. DATE OF DEATH Month 1 Day 2 Year 1961			
5 SEX M	6. COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1872		9 AGE (In years lost birthday) 88 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Jackson Houck				14. MOTHER'S MAIDEN NAME Annie Elizabeth Lock			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO none		INFORMANT Asbury Home records		Address Gaithersburg, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 17 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) 20f (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15 , 1960, to Jan 2 , 1961, that I last saw the deceased alive on Dec 30 , 1960, and that death occurred at 9:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7720 Wisconsin Ave. Bethesda, Md. DATE SIGNED 1-2-61							
ACTUAL SIGNATURE James W. Egan M.D.				PHYSICIAN'S NAME (Type) James W. Egan			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 1-5-61		22c. NAME OF CEMETERY OR CREMATORY Rose Grove Church		22d. LOCATION (City, town, or county) (State) Frederick Md.	
23 FUNERAL DIRECTOR'S SIGNATURE Shirley E. Carter				ADDRESS Gaithersburg, Md.		24a REC'D BY REGISTRAR JAN 4 1961	
24b. REGISTRAR'S SIGNATURE Carlton S. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

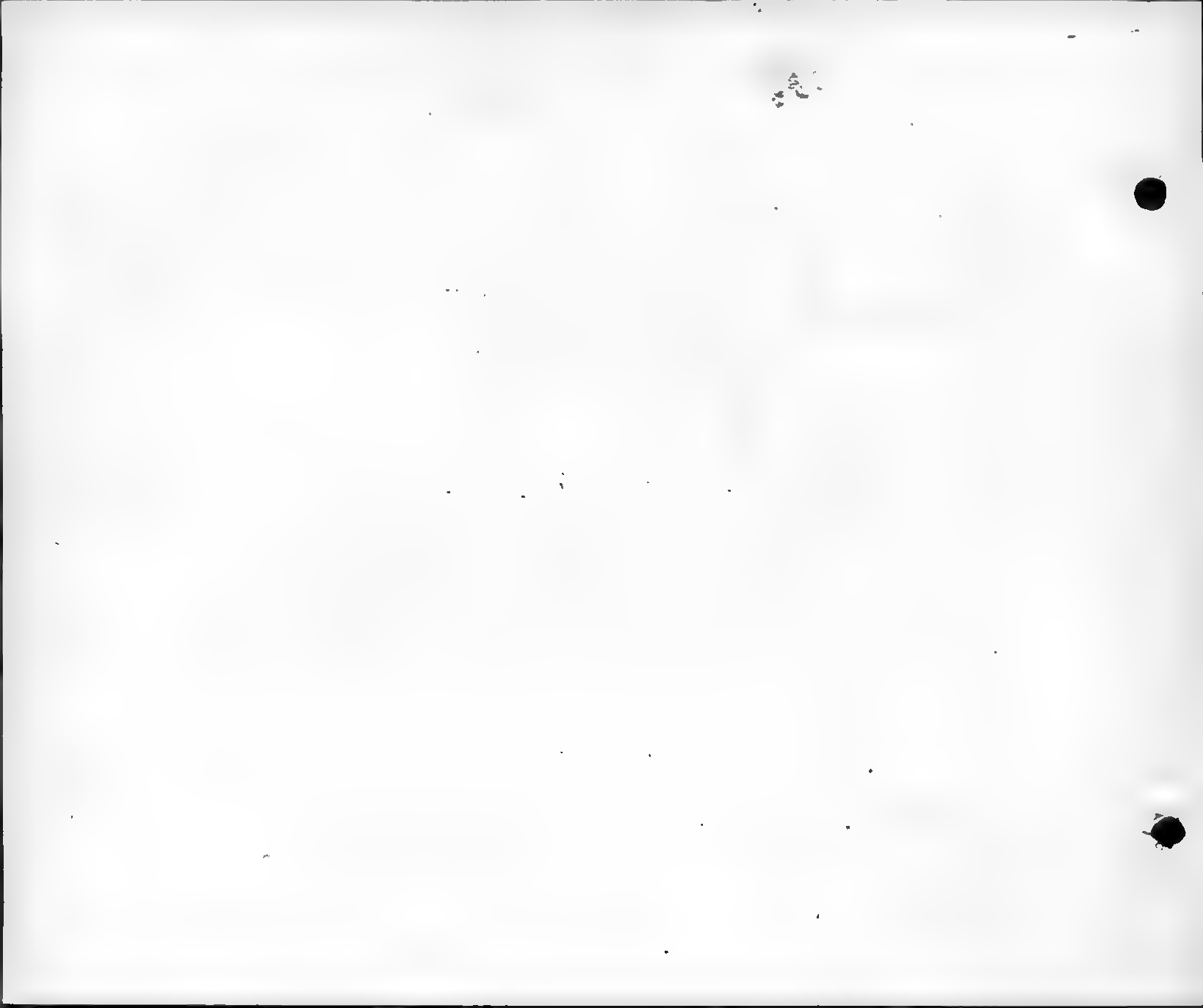
10845

352

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Phillips</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2000 Rockville Avenue</u>				d. STREET ADDRESS <u>Phillips</u>			
3. NAME OF DECEASED (Type or print) First <u>B. RARRA</u> Middle <u>HROUDA</u> Last <u>J. MARR</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/33</u>		9. AGE (In years last birthday) <u>27</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>----</u>		INFORMANT <u>Agnes Triebull - Item # 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>arteriosclerotic Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 weeks</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-15-60</u> , 19 <u> </u> , to <u>1-2-61</u> , 19 <u> </u> , that I last saw the deceased alive on <u>1-2-61</u> , 19 <u> </u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>William Frank</u> M.D. <u>1/3/61</u> DATE SIGNED							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>William Frank</u> <u>-544 W/ Montgomery Avenue, Rockville, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>B. RARRA</u>		<u>1/2/61</u>		<u>St. Patrick's</u>		<u>Phillips, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Wheeler-1011 E. Montgomery Ave. Rockville</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



353

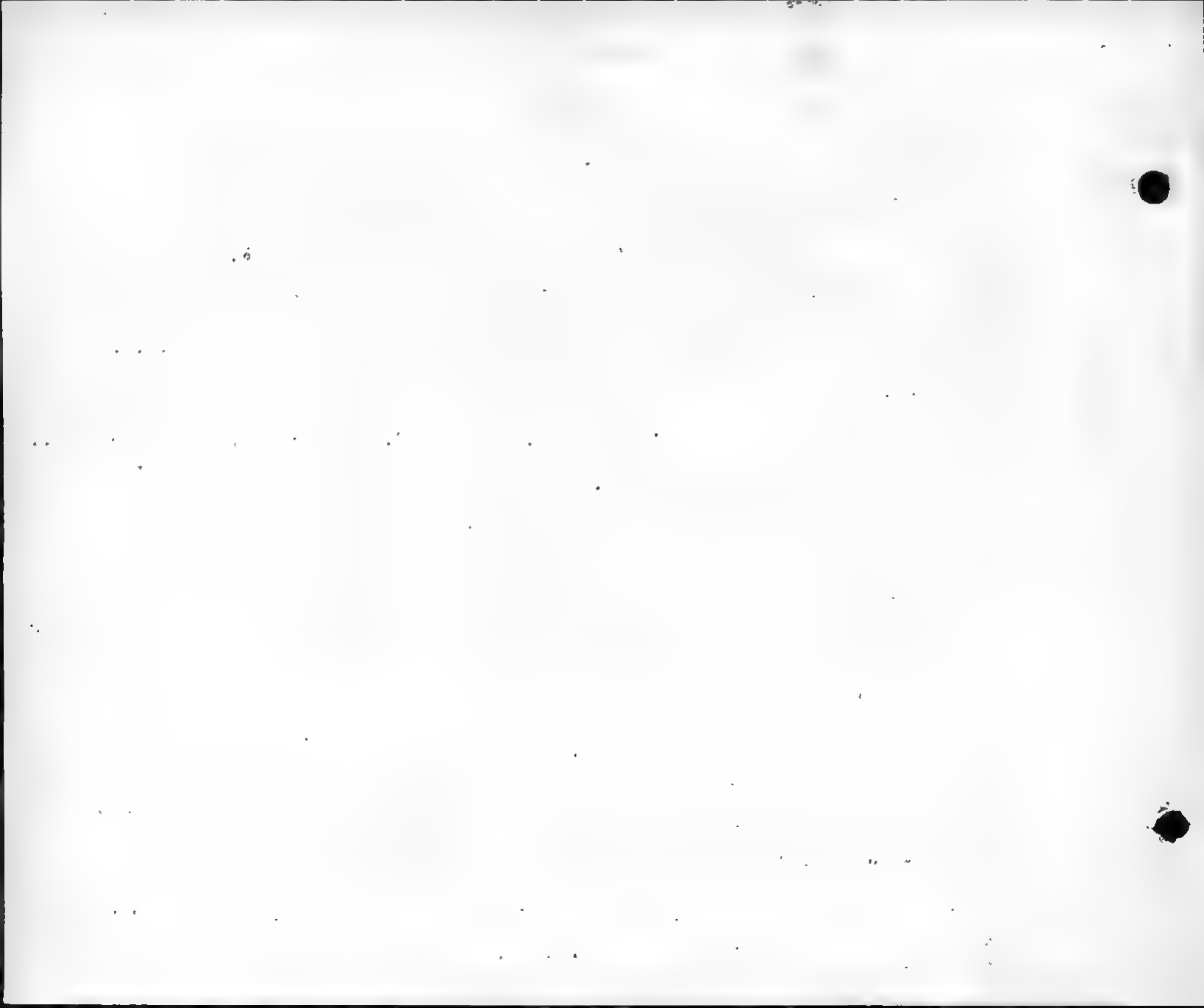
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 5 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8706 GILBERT PLACE		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8706 GILBERT PLACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAE Middle HILMA Last HUNTER		4. DATE OF DEATH Month JAN. Day 14 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/78
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min 82	11. IF UNDER 24 HRS Months 82 Days 82 Hours 82 Min 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWARD JOHNSON	
14. MOTHER'S MAIDEN NAME EMMA JOHNSON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Virginia G. MacWilliams, 8706 Gilbert Pl. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/22, 1960 to 1/13, 1961 that I last saw the deceased alive on 1/13, 1961 and that death occurred at 8:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bennett A. Robin M.D.		DATE SIGNED 1/16/61	
PHYSICIAN'S NAME (Type) BENNETT A. ROBIN		SILVER SPRING, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/17/61	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC. ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JAN 25 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
854 CERTIFICATE OF DEATH

10847

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash - D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resman Hospital and Sanitarium</u>				e. STREET ADDRESS <u>627 Whitier St N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>E</u> Last <u>Hutchinson</u>				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 26 - 1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u>81</u> Days <u>81</u> Hours <u>81</u> Min <u>81</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Jefferson Vandersdale</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Ziles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>not</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Broncho-pneumonia,</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>2 RT Hemiplosia</u> <u>Arteriosclerosis Generalized of Undetermined</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterial Hypertension</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour <u>am</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 9</u> to <u>Jan 31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 31</u> , 19 <u>61</u> , and that death occurred on <u>Jan 31</u> , 19 <u>61</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>George L Ball</u>				22b. DATE SIGNED <u>Jan 31, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>George L Ball</u>	
23a. BLR A. CREMATION REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>2/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>	
23d. LOCATION (City, town or county) <u>Westernport, Md.</u>				23e. REC'D BY REGISTRAR <u>DATE FEB 2 '61</u>		23f. REGISTRAR'S SIGNATURE <u>Clifford L. House</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

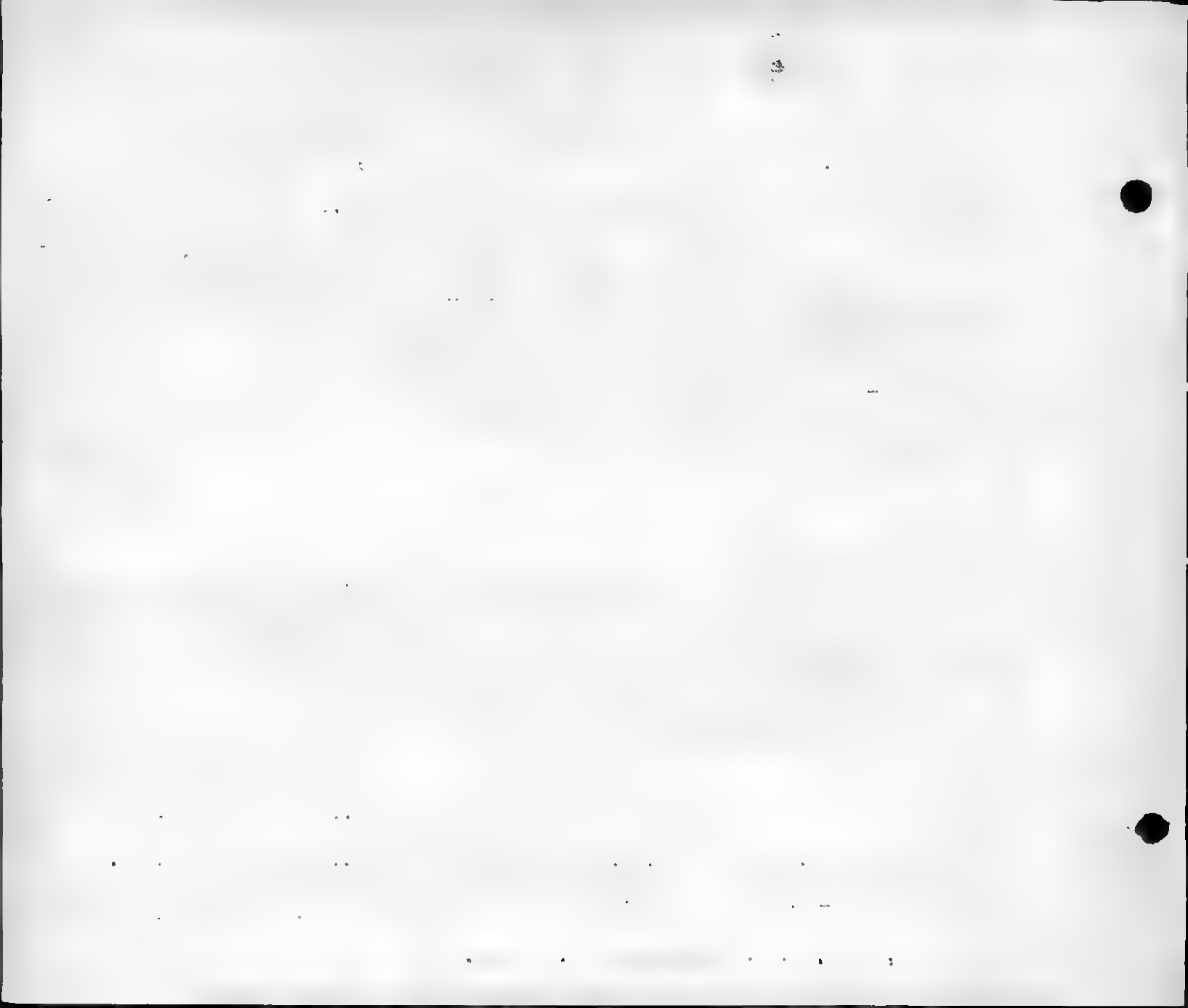
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66848

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19 Takoma Park</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>8600 Flower Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Hutchison</u> Last <u>Hutchison</u>		4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>19 61</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-61</u>	
9. AGE (In years last birthday) yrs. <u>10</u>		IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>10</u>		
13. FATHER'S NAME <u>Glenn Hutchison</u>		14. MOTHER'S MAIDEN NAME <u>Dolores Byer Beeghly</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>		
17. INFORMANT <u>mother</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>Valgene M. Milstead, M.D. 1110 Spring St., Silver Spring, Md. 4/31/61</u>				
ACTUAL SIGNATURE <u>Valgene M. Milstead, M.D.</u>				
PHYSICIAN'S NAME (Type) <u>Valgene M. Milstead, M.D.</u> <u>1110 Spring St., Silver Spring, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>1-31-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital, Takoma Park, Maryland</u>	22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D. Washington San. & Hosp.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 2 '61</u>		
24b. REGISTRAR'S SIGNATURE <u>C. S. Evans</u>				

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

356

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 12 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 811 Patton Dr

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 1811 Patton Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Louis Ishtin
4. DATE OF DEATH Jan 6 1961
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 5-21-1891 9. AGE (In years, last birthday) 69 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor 10b. KIND OF BUSINESS OR INDUSTRY Roofing 11. BIRTHPLACE (State or foreign country) Russian 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Kalman Ishtin 14. MOTHER'S MAIDEN NAME MINNIE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 099-01-1335 17. INFORMANT Rose Ishtin Address Stem 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
4-20-61 DUE TO
Conditions, if any, which gave rise to immediate cause (b) _____
(a), stating the underlying cause last. DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____

20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ at work Not While ☐ at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 1-6-61

EXAMINER'S NAME (Type) FRANK J. Broschart Address (Street, city, town, or county) _____

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 1-8-61 22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN FALLS CHURCH 22d. LOCATION (City, town, or country) VA.

23. FUNERAL DIRECTOR B. DANZANSKY + SONS - 3501 - 14th ST. N.W. ADDRESS _____ 24a. REC'D BY REGISTRAR JAN 9 '61 24b. REGISTRAR'S SIGNATURE C. J. J. J.

10

11

12

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the appropriate section of this certificate should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00850

1. PLACE OF DEATH a. COUNTY Montgomery County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before arrival on) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 days 13hrs. 45min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				d. STREET ADDRESS 302 Frederick Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ray (NMN) Jefferies				4. DATE OF DEATH Month Day Year January 29 19 61			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 26, 1888	
9. AGE (In years last birthday) yrs 72		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired RR. Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? United States				13. FATHER'S NAME Evan Moore Jefferies			
14. MOTHER'S MAIDEN NAME Mary Elizabeth Crossland				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Hospital Records				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Transverse Colon 153.1 DUE TO (b) Mitochondria to liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Marked emphysema of lungs INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 29, 1960 to Jan. 29, 1961 , that (I) (we) last saw the deceased alive on Jan. 28, 1961 , and that death occurred at 5:30 M, from the causes and on the date stated above.							
22a. SIGNATURE Jack Schumacher				22b. DATE SIGNED 1-29-61		22c. PHYSICIAN'S NAME (Type) Jack Schumacher, M.D.	
23a. BURIAL, CREMATION, RECOVERY (Specify) Burial				23b. DATE THEREOF 2-1-61		23c. NAME OF CEMETERY OR CREMATORY Oak Grove	
23d. LOCATION (City, town, or county) (State) Uniontown Pa				24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.			
25a. REC'D BY REGISTRAR DATE FEB 2 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

1. The first part of the report
describes the general situation
of the country and the
state of the economy.
2. The second part of the report
describes the state of the
economy and the state of the
economy.
3. The third part of the report
describes the state of the
economy and the state of the
economy.
4. The fourth part of the report
describes the state of the
economy and the state of the
economy.

1. The first part of the report
describes the general situation
of the country and the
state of the economy.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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358

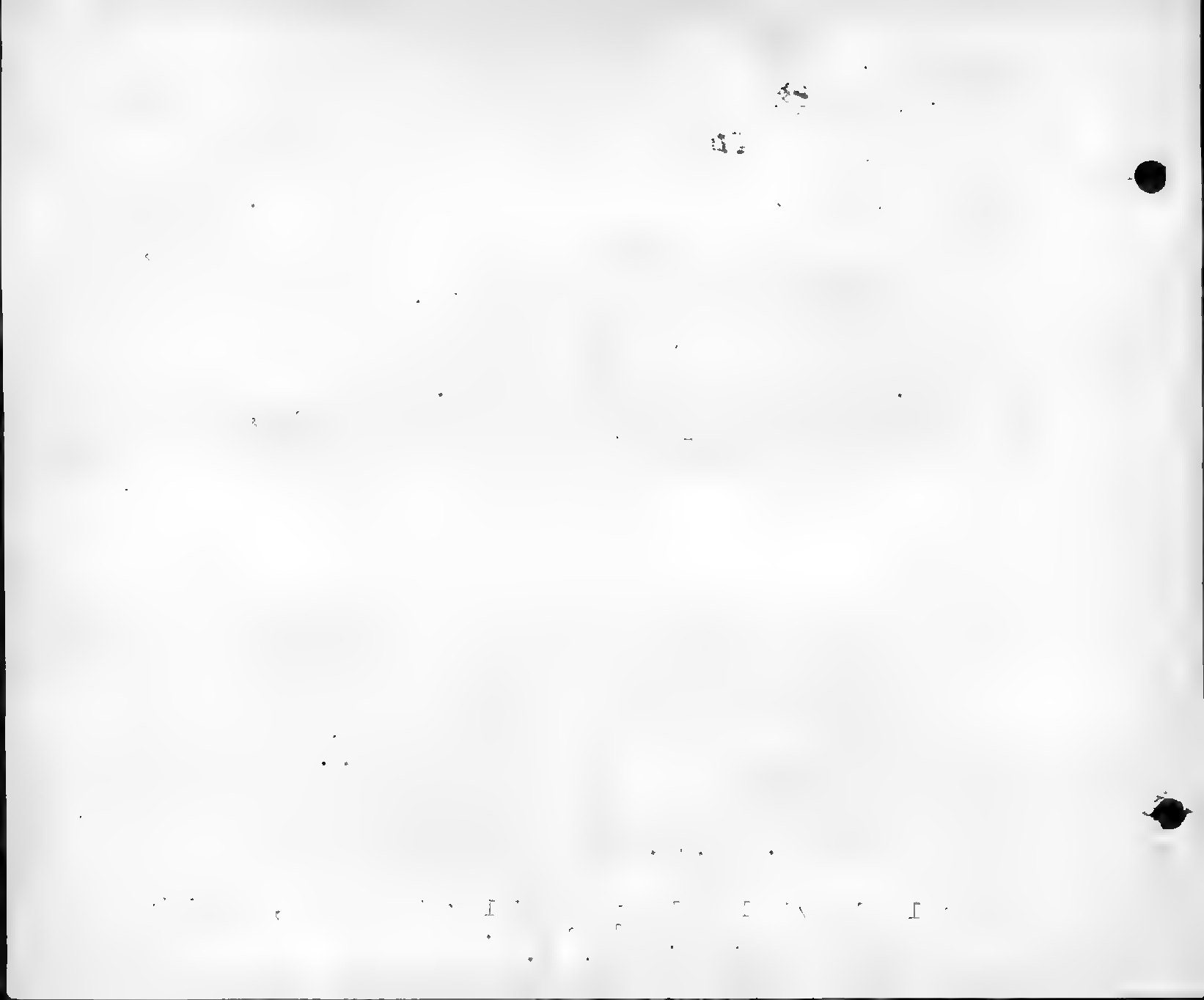
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60851

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle Anthony Last Jewby		4. DATE OF DEATH Month January Day 26 Year 1961	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH December 6, 1901
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 8 Days 2	11. IF UNDER 24 HRS Hours 2 Min 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technical Writer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Jewby		14. MOTHER'S MAIDEN NAME Anna M. Bincowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. 226-56-3926	
17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland		18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia and Septicemia 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Myeloma DUE TO (c) 8 Months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m 19 p. m		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from September 29, 1960 to January 26, 1961 , that (I) (we) last saw the deceased alive on January 26, 1961 , and that death occurred at 7:20 a.m. from the causes and on the date stated above			
22a. SIGNATURE Vincent H. Bono Jr M.D.		22b. DATE SIGNED 1/26/61	
22c. PHYSICIAN'S NAME (Type) Vincent H. Bono, Jr., MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/30/1961	
23c. NAME OF CEMETERY OR CREMATORY Calvary Memorial Park		23d. LOCATION (City, town, or county) (State) Fa, rfax, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Douglas L. Rindoff		25a. REC'D BY REGISTRAR 3245 Wilson Blvd. Arlington, Va.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE JAN 30 '61	

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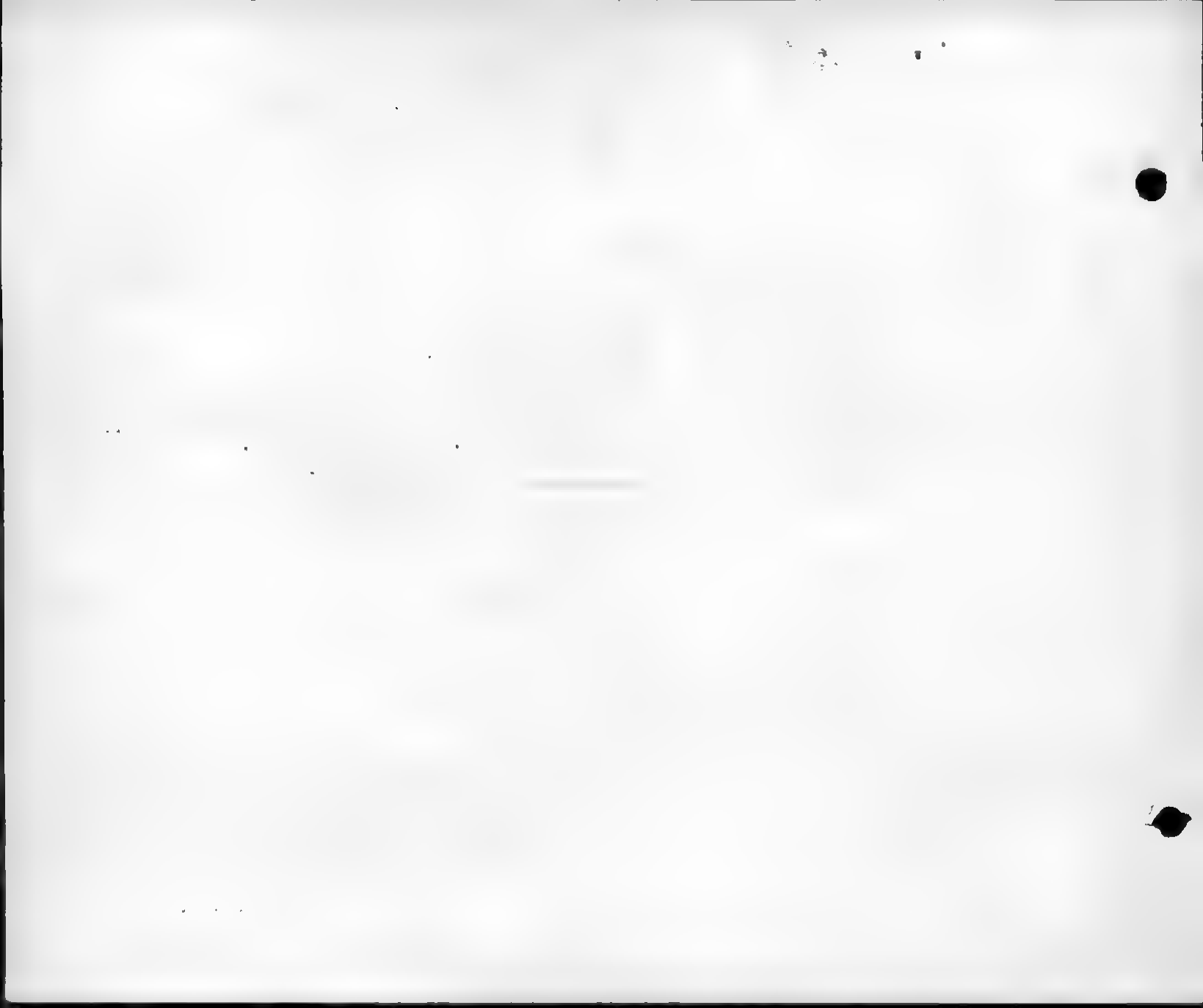
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

359

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60852

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>7308 Alaska Ave. N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jeanette Sigmund Kaufman</u>				4. DATE OF DEATH Month Day Year <u>Jan 21 19 61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/73</u>	9. AGE (in years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Sigmund</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Newmyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Sydney C. Kaufman 7308 Alaska Ave. NW Wash. DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>495 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia - Left Lung -</u> DUE TO (c) <u>3 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lung Tumor. Left lung -</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21 I certify that (I) (this hospital) attended the deceased from <u>1/20</u> <u>1961</u> to <u>1/21</u> <u>1961</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>1/21</u> <u>1961</u> , and that death occurred at <u>11:21 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John S. Ball</u>				22b. DATE SIGNED <u>1/22/61</u>		22c. PHYSICIAN'S NAME (Type) <u>John S. Ball</u>	
22d. ADDRESS <u>7936 Georgetown Rd. Bethesda 14 Md</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation 1/23/1961</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudin's Sons, Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>JAN 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



1 FOR STATE HEALTH DEPT.

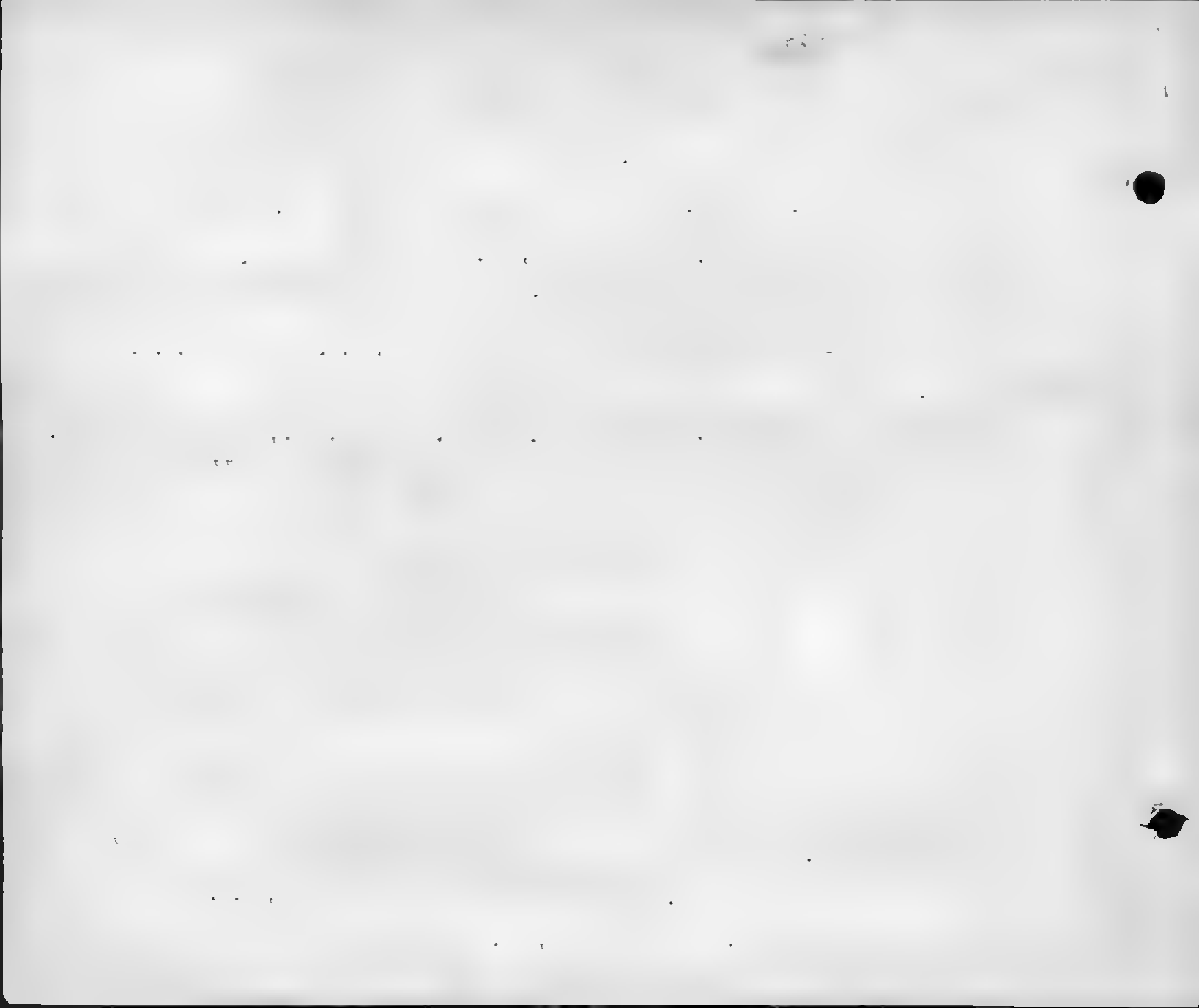
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de- necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

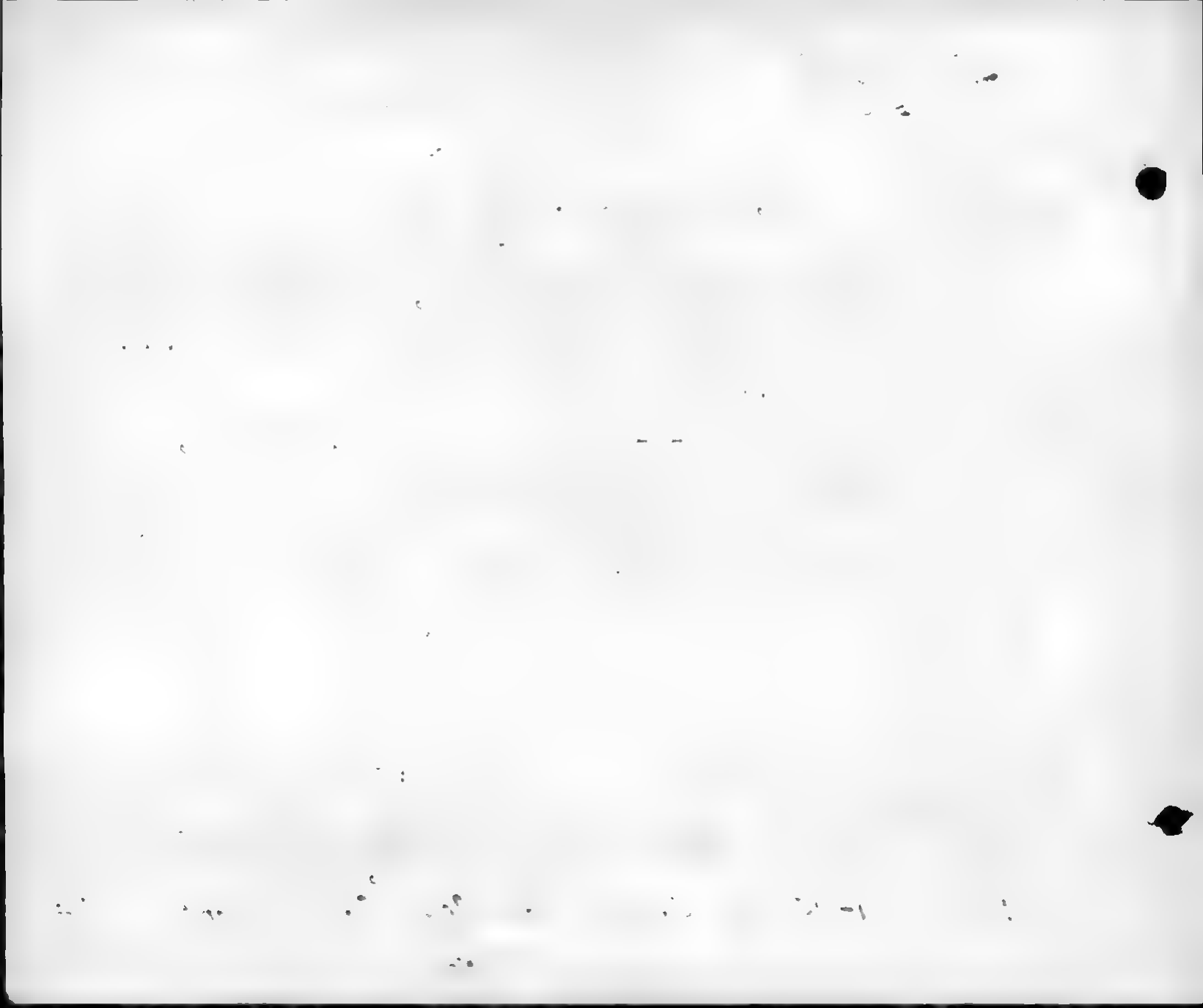
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60853

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 18 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8313 GARLAND AVE. Apt. #3		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK d. STREET ADDRESS 8313 GARLAND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN KEARNEY, SR.		4. DATE OF DEATH Month JAN. Day 26 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/20/89		9. AGE (in years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skip Tracer(self-employed)		10b. KIND OF BUSINESS OR INDUSTRY Commercial Accounts		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME JAMES P. KEARNEY		14. MOTHER'S MAIDEN NAME EVA BEHRENS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 071-01-1541-A		17. INFORMANT Address Mr. John L. Kearney, Jr., 7104 Annapolis Rd. Landover Hills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Condition, any, which gave rise to immediate cause (b) 420-1 (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Diabetic Mellitus					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. FRANK J. BROSCHART		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/30/61		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	
22d. LOCATION (City, town, or country) WASHINGTON, D.C.		22e. (State)			
23. FUNERAL DIRECTOR W. P. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR FEB 3 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE 1/27/61			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

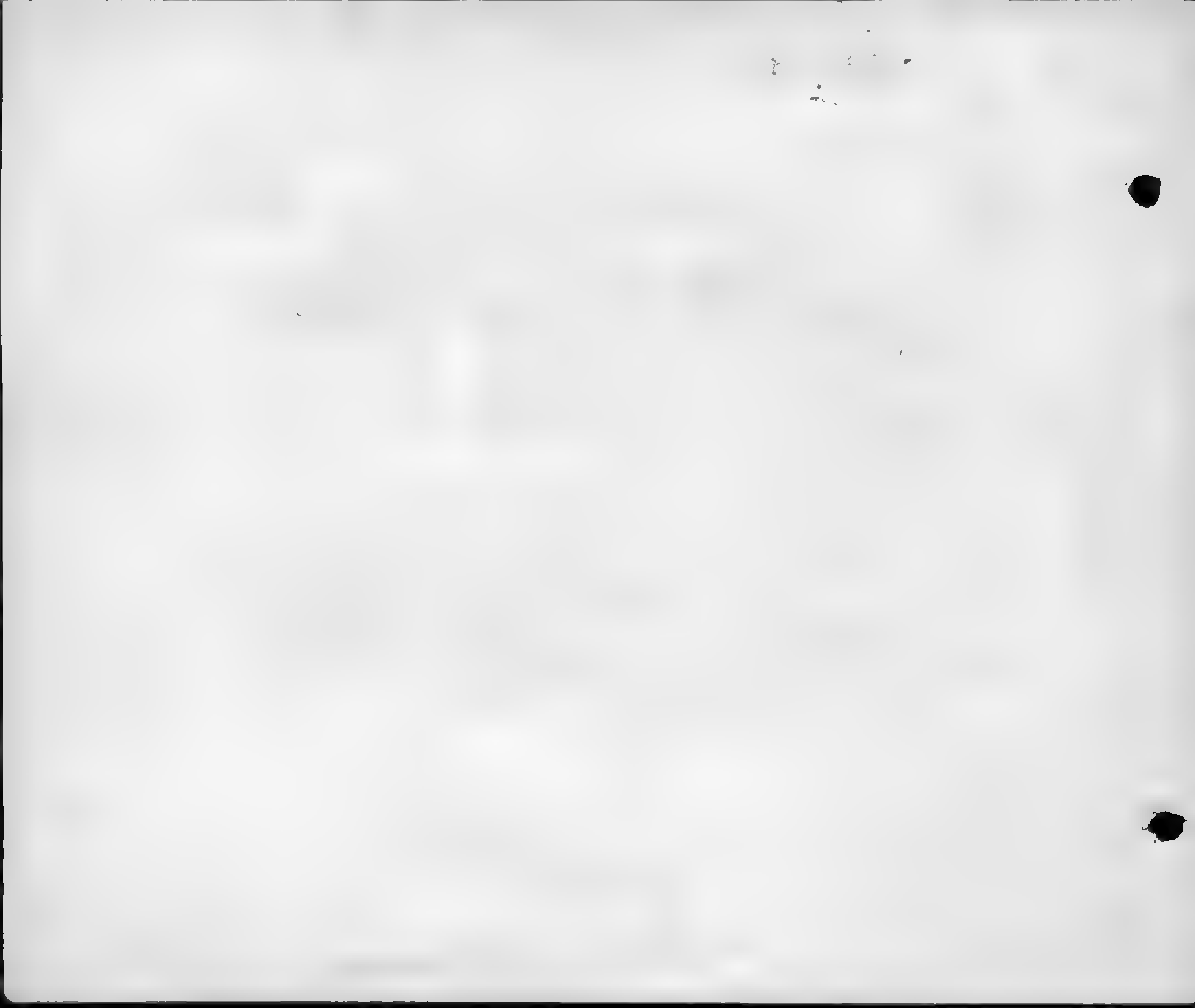
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 18 hours		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges Co.	
c. NAME OF DECEASED (Type or print) Patrick Kevin Kelly		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hospital		e. STREET ADDRESS 1404 Torrey Place		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		g. DATE OF DEATH Month January Day 4 Year 1961	
3. NAME OF DECEASED (Type or print) Patrick Kevin Kelly		4. DATE OF DEATH Month January Day 4 Year 1961		5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH August 5, 1896		9. AGE (In years) (If under 1 year, if under 24 hrs., last birthday) 64 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? Amer.		13. FATHER'S NAME John Kelly		14. MOTHER'S MAIDEN NAME Julia O'Donnell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 6842	
17. INFORMANT Chact		Address Washington San. Hosp.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE (b) PULMONARY HEMORRHAGE (c) STRUCK BY AUTOMOBILE		INTERVAL BETWEEN ONSET AND DEATH 6-8 HRS.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. MULTIPLE FRACTURES OF LOWER EXTREMITIES		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Reflected stump by hit + run auto. (pedestrian)		20c. TIME OF INJURY Month 1-3 Day 1 Year 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) Green Meadows P.O. Md		20g. (County) Prince Georges Co.		20h. (State) Md		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-7-61		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or country) Wash. DC		22e. (State) DC	
23. FUNERAL DIRECTOR Horton Funeral Home		ADDRESS 3831 9th St. N.W., Wash. DC		24a. REC'D BY REGISTRAR 1-4-61		24b. REGISTRAR'S SIGNATURE W. S. Hines		DATE SIGNED 1-4-61	



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TO HOSPITAL by the attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be returned by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
863
CERTIFICATE OF DEATH

00856

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>		d. STREET ADDRESS <u>11109 DEVERE DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>CELIA</u> First M'ddle Last <u>HEROES</u>		4. DATE OF DEATH <u>JAN 25 1961</u> Month Day Year	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1896</u>
9 AGE (In years or birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES TAISHOFF</u>		14. MOTHER'S MAIDEN NAME <u>EDITH FRIEDLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-12-3785</u>	
17. INFORMANT <u>EDITH HOROWITZ</u> Address <u>1109 DEVERE DR S. SPG. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>422.1</u> DUE TO <u>Arteriosclerotic Cerebrovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>January 14, 1961</u> to <u>January 25, 1961</u> . That (I) (we) last saw the deceased alive on <u>19 January 1961</u> and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Boris Rabkin</u>		22b. DATE <u>Jan 25, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		22d. ADDRESS <u>1019 University Blvd East</u>	
22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/26/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lokey Funeral Home</u> ADDRESS <u>4717-9th Ave</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 27 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>William S. Kraw</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

60857

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE DC b. COUNTY 4-X	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ALTHEA WOODLAND HOME		d. STREET ADDRESS 5012 Arkansas Ave NW	
3. NAME OF DECEASED (Type or print) First EMILIE Middle S. Last KESSLER		4. DATE OF DEATH Month Jan Day 6 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 27, 1872
9. AGE (In years last b. day) 88 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME CHRIS F. FENDNER		14. MOTHER'S MAIDEN NAME SOPHIA EBERTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT EMMA KESSLER		Address 5012 Arkansas Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension moderate		INTERVAL BETWEEN ONSET AND DEATH 3 wks 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1960 to Jan. 6, 1961 , that I last saw the deceased alive on Jan. 5, 1961 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel M. Bageant		ADDRESS (Street, city or town, state) 5600 N.H. Ave Wash DC	
PHYSICIAN'S NAME (Type) Samuel M. Bageant, M. D.		DATE SIGNED 1/7/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-61	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home		24a. REC'D BY REGISTRAR JAN 11 '61	
ADDRESS 4812 G. Ave NW		24b. REGISTRAR'S SIGNATURE 1-8-61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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863
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00858

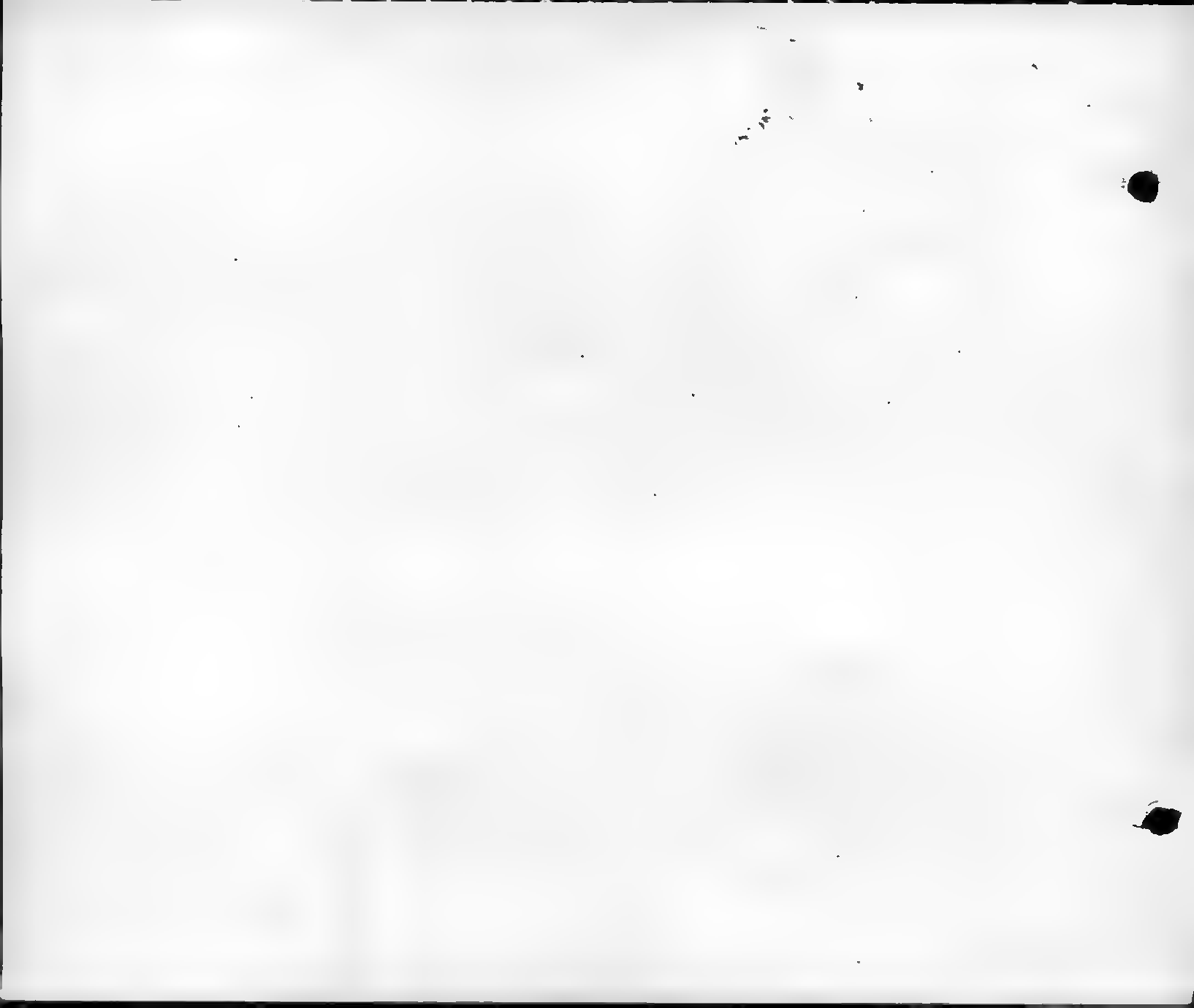
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>59</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Tuberculosis</u>				d. STREET ADDRESS <u>1778 - Child St. N. W. Wash. D.C.</u>			
3. NAME OF DECEASED (Type or print) First <u>BESS</u> Middle <u>K</u> Last <u>KICKLIGHTER</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1885</u>		9. AGE (In years last birthday) <u>75</u> yrs	IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Veterans' Bureau, Indiana</u>		11. BIRTHPLACE (State or foreign country) <u>US</u>	
13. FATHER'S NAME <u>Alfred S. Kimball</u>				14. MOTHER'S MAIDEN NAME <u>Julia Reynolds</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>St. L. Kimball</u> Address <u>2720 Old Chesapeake Rd. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4:41</u> <u>Congestive heart failure and myocarditis</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21 I certify that (I) this hospital attended the deceased from <u>Apr. 1961</u> to <u>29 Jan. 1961</u> , that (I) (we) last saw the deceased alive on <u>28 Jan. 1961</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert Martyn Jr</u>		M. D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/> <u>29 Jan 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>		22b. ADDRESS <u>5029 Bethesda Ave</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/2/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town or county) <u>Arlington Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>		

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
15M 9/59

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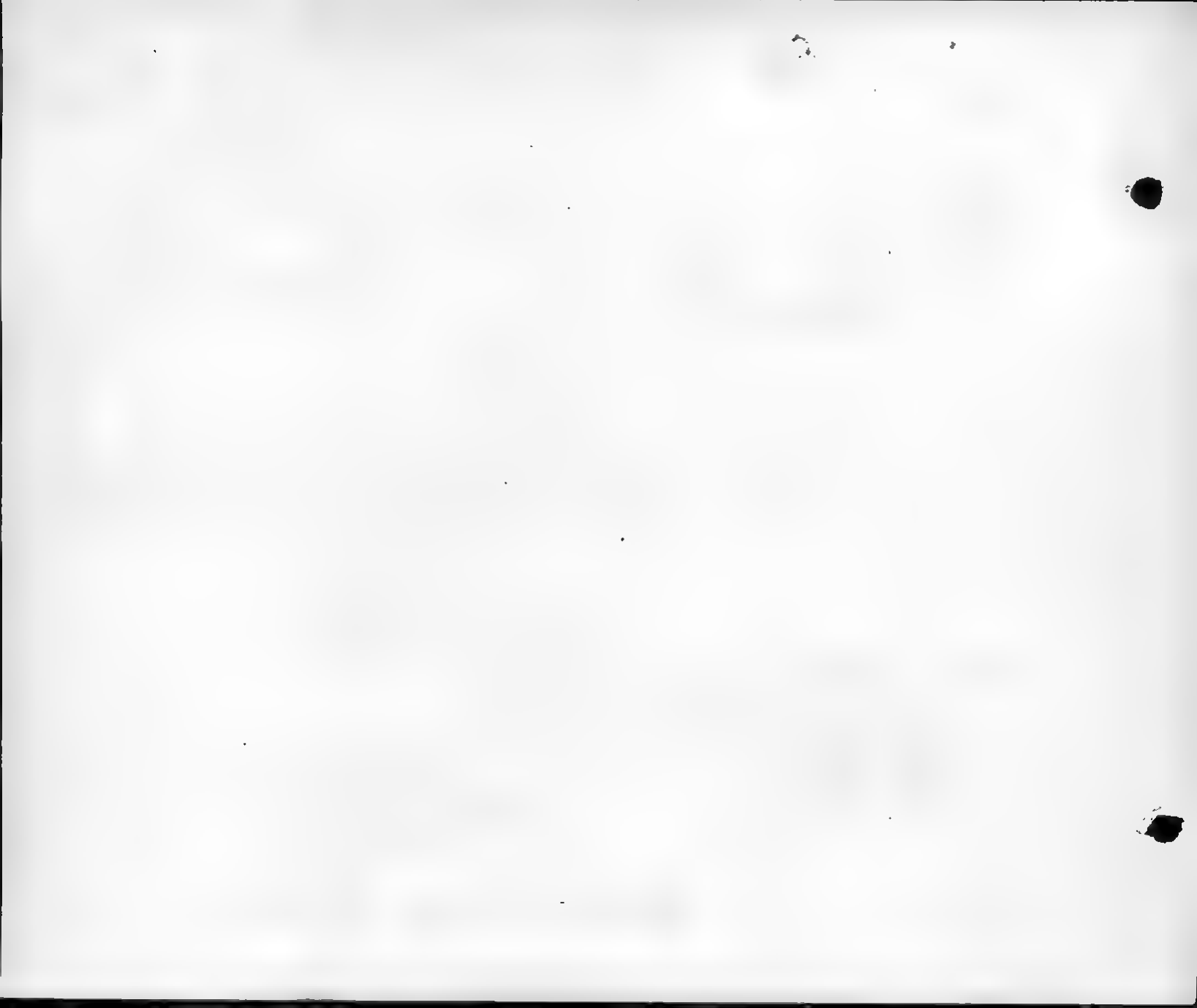
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

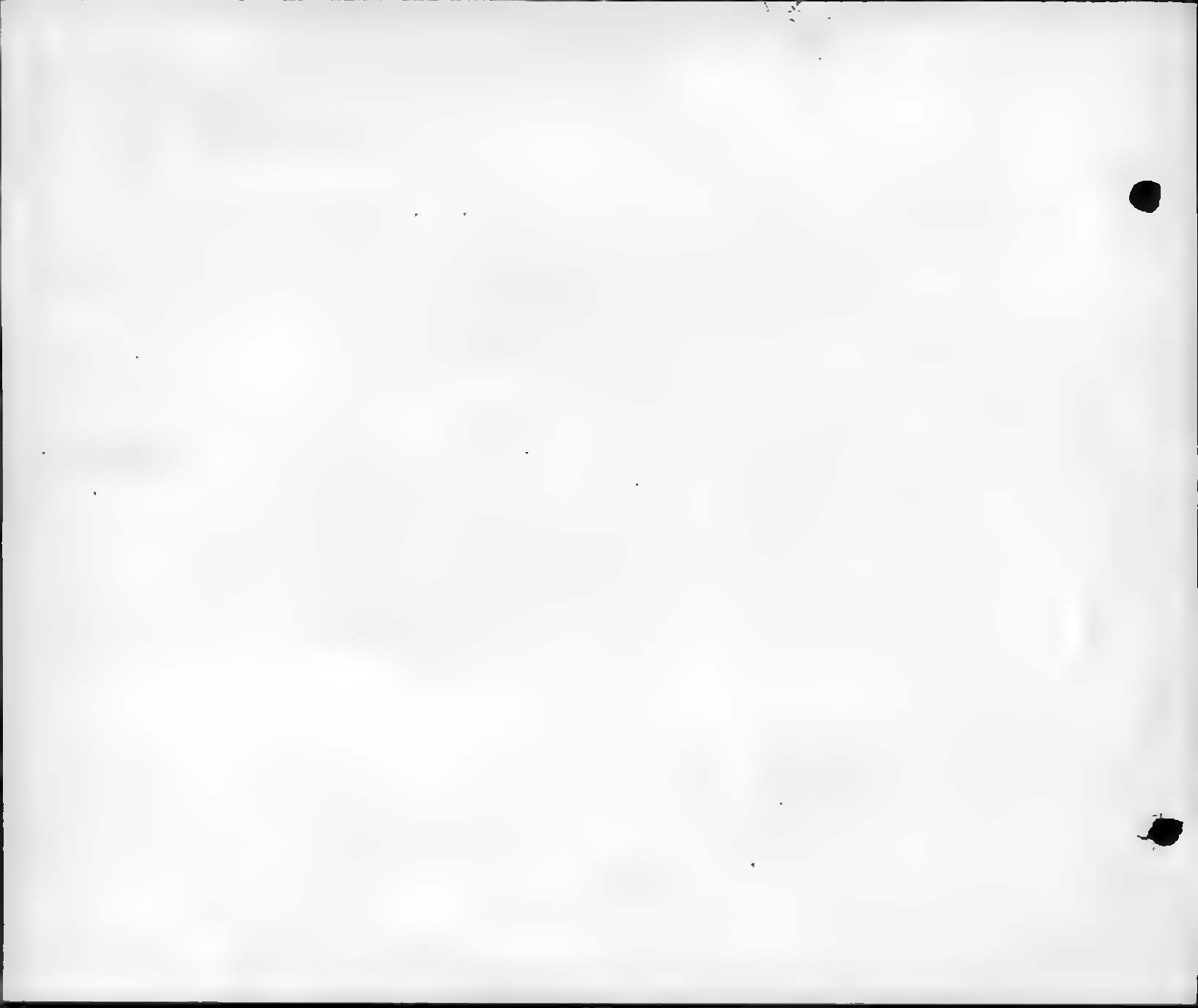
00859

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>29 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp</u>				d. STREET ADDRESS <u>3716 Valley Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Adelaide Kathryn (1st) Kiebach</u>				4. DATE OF DEATH Month Day Year <u>Jan. 11 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1917</u>	
9. AGE (In years last birthday) <u>43</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. JSUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City of Alexandria</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Boucher Hacker</u>				14. MOTHER'S MAIDEN NAME <u>Florence Merkel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic carcinoma of the ovary</u>							
DUE TO (b) <u>ovary</u>							
DUE TO (c) <u>ovary</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>175.0</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/12/60</u> to <u>1/11/61</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>1/11</u> 1961, and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>K. A. [Signature]</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>K. A. [Signature]</u>				22d. ADDRESS <u>1110 Spring St Silver Spring Md</u>			
23a. BURIAL CREMATION <u>BURIAL</u>		23b. DATE THEREOF <u>1-16-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City, town, or co.) (State) <u>ARLINGTON CO. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Emily Whittley F. Home</u>				25a. REC'D BY REGISTRAR <u>1/16/61</u>			
ADDRESS <u>Ulf, VA.</u>				25b. REGISTRAR'S SIGNATURE <u>Wm. S. [Signature]</u>			

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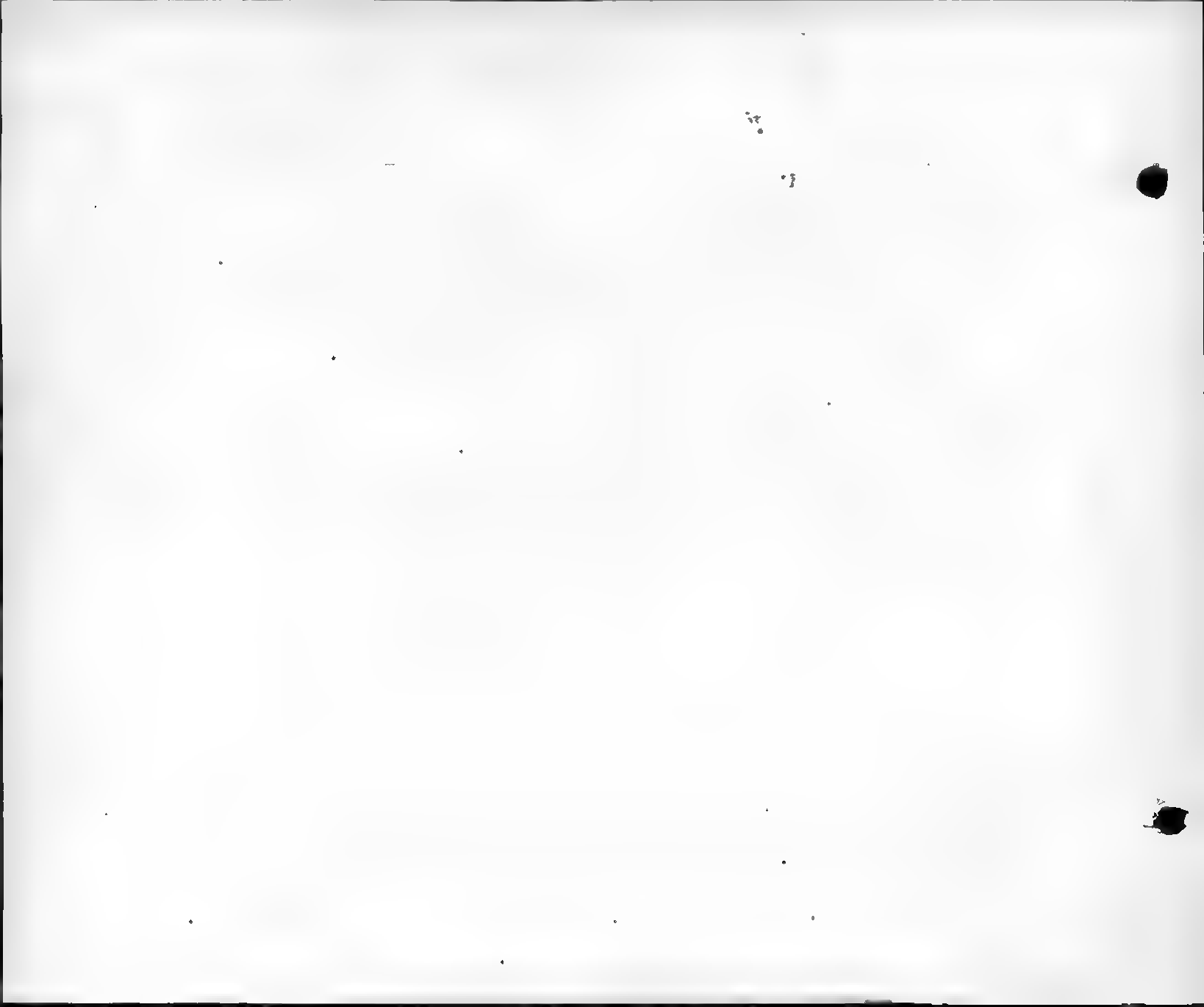
368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Purdum</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD # 1, Monrovia</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bonnie</u> Middle <u>Jean</u> Last <u>King</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1952</u>
9. AGE (In years last birthday) <u>8 yrs</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Purdum, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Earl V. King</u>		14. MOTHER'S MAIDEN NAME <u>Mildred F. Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>---</u>	
17. INFORMANT <u>Earl V. King, Item 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>751X Congenital hydrocephalus</u> DUE TO (b) <u>Congenital meningococci</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/27</u> , 19 <u>52</u> to <u>1/3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11/20</u> , 19 <u>60</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>James P. Kerr</u> M.D.		ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>		DATE SIGNED <u>1/3/61</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 5, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		22d. LOCATION (City, town, or county) (State) <u>Purdum, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kline</u> ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 6 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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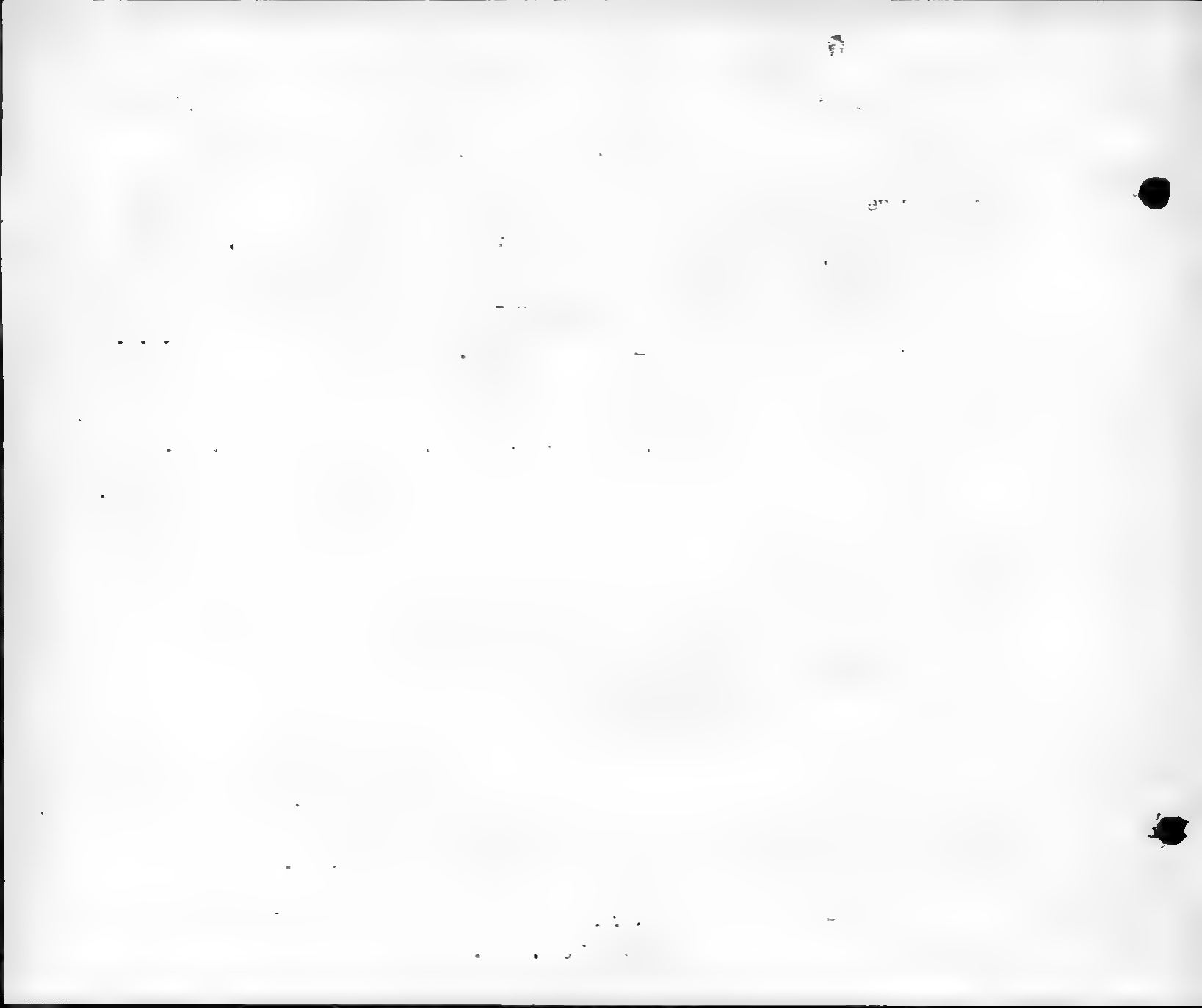
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 1 Year d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Sybell Last King		4. DATE OF DEATH Month Jan. Day 28 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-80
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min 80	11. IF UNDER 24 HRS Months 80 Days 80 Hours 80 Min 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Ward		14. MOTHER'S MAIDEN NAME Ida Warfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
INFORMANT Glenwood D. King		Address Damascus, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Atherosclerotic cardiovascular disease DUE TO (b) 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/15 , 19 45 to 1/28 , 19 61 , that I last saw the deceased alive on 1/27 , 19 61 , and that death occurred at 2:25 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Damascus, Md.	
PHYSICIAN'S NAME (Type) James P. Kerr		DATE SIGNED 1/28/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-61	
22c. NAME OF CEMETERY OR CREMATORY Damascus		22d. LOCATION (City, town, or county) (State) Damascus, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Francis G. Barber		24a. REC'D BY REGISTRAR Laytonville. Md.	
24b. REGISTRAR'S SIGNATURE DATE FEB 2 '61		24c. REGISTRAR'S SIGNATURE A. C. S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this cert. has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/51

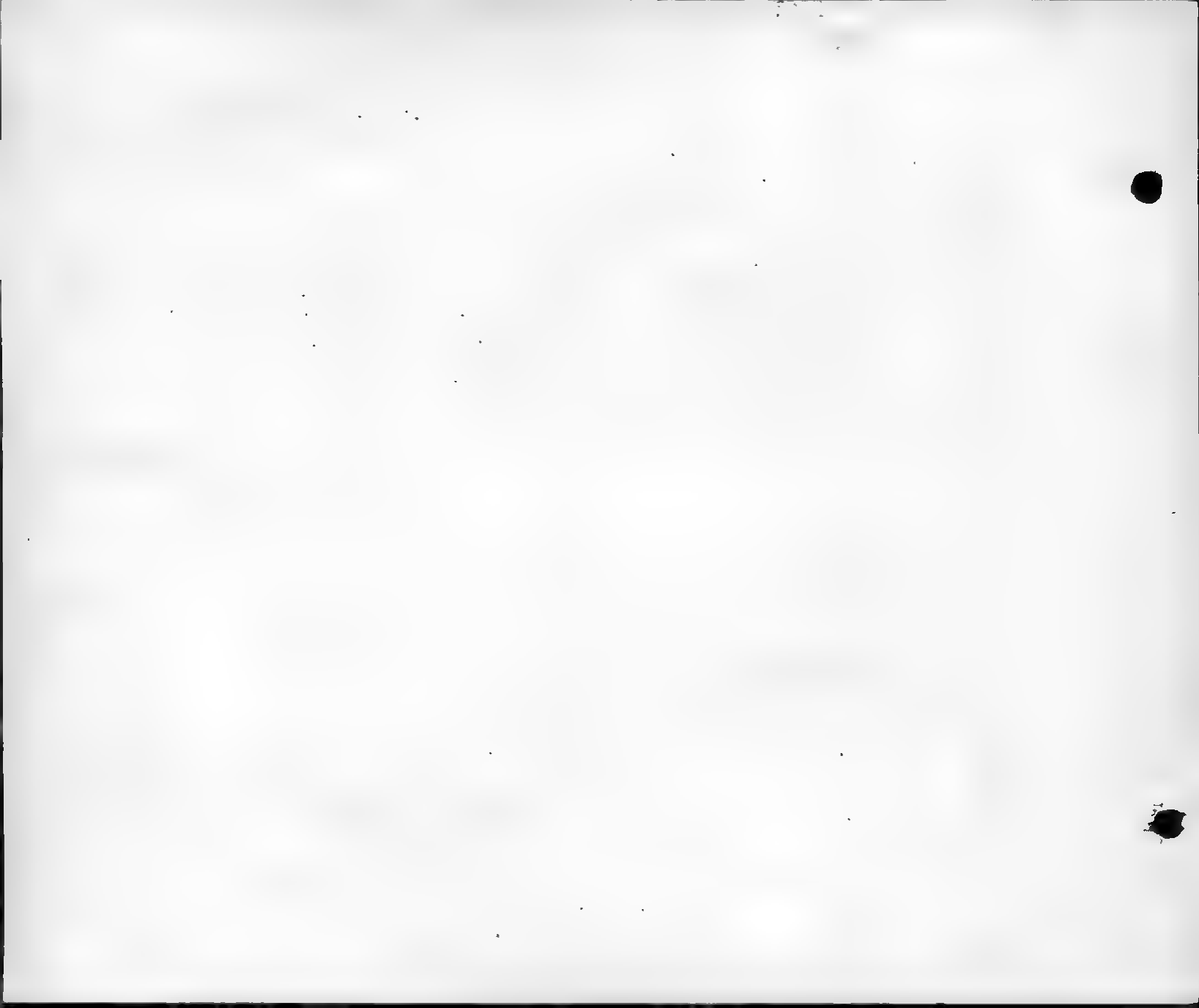
1

870

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00863

1. PLACE OF DEATH a. COUNTY: <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE: <u>Maryland</u> b. COUNTY: <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>37 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>701 Ritchie Avenue</u>				d. STREET ADDRESS <u>701 Ritchie Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE ELIZABETH KNIGHT</u>				4. DATE OF DEATH Month Day Year <u>January 1 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/15/23</u>	
9. AGE (In years last birthday) <u>37 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min <u>1 1 1 0</u>		IF UNDER 24 HRS Hours Min <u>1 0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Whitney Walter</u>				14. MOTHER'S MAIDEN NAME <u>Beatrice Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-26-1251</u>		17. INFORMANT <u>Whitney Walter</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Dehydration & malnutrition</u> 6 days							
(b) <u>Cancer of Ovary & Metastases</u> 6 months							
(c) <u>lying cause lost.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>175.0</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>October 12, 1960</u> , to <u>January 1, 1961</u> , that (I) <u>last</u> saw the deceased alive on <u>12/30</u> 19 <u>60</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Arnon A. Laine</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arnon A. Laine</u>				22d. ADDRESS <u>Georgetown Link Hwy, Mount Airy, N.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 4, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

871

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>S. ARLINGTON</u>	
c. LENGTH OF STAY IN 1b <u>12/6/60 1/16/61</u>		d. STREET ADDRESS <u>2926 2nd St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>LABUDA</u>		4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1 - 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CARL BRINDY</u>		14. MOTHER'S MAIDEN NAME <u>MARY BRINZA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260X</u> DUE TO <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost <u>Diabetes Mellitus</u> (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 7</u> 19 <u>60</u> to <u>Jan 16</u> 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 15</u> 19 <u>61</u> , and that death occurred at <u>9:45</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u> M.D.		DATE SIGNED <u>1019 University Boulevard 1/16/61</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>		<u>Silver Spring Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JAN. 29 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Northside Catholic Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pittsburg, PENN.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. Humphrey</u>		24a. REC'D BY REGISTRAR <u>JAN 25 '61</u>	
ADDRESS <u>8434 E. Ave. S.S. Md.</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



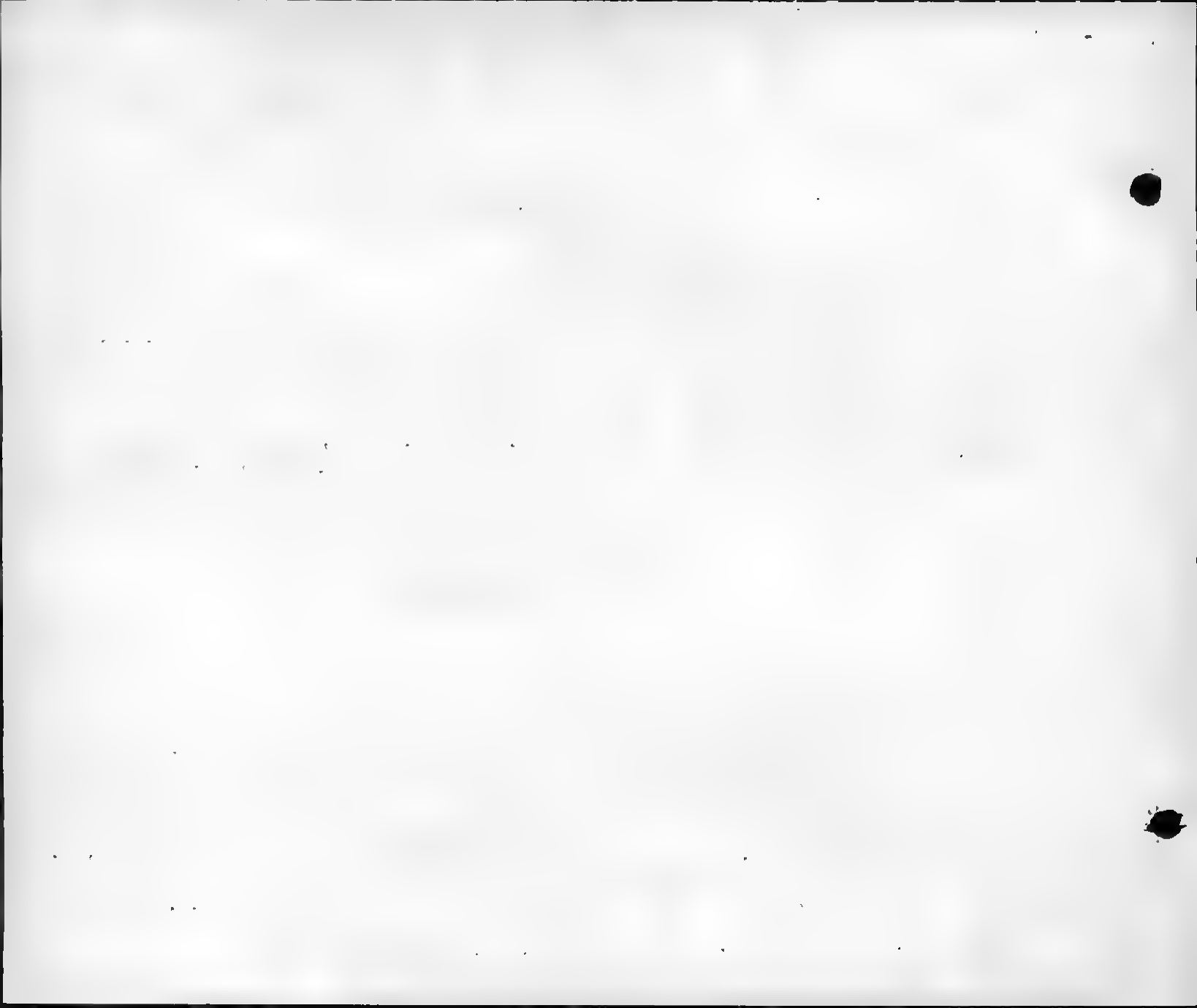
872

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60865

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resner Hospital and Sanitarium</u>				STREET ADDRESS <u>1801 GRACE CHURCH ROAD</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Ellen Landgraf</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <u>Jan</u> Day <u>23</u> Year <u>1961</u>	
8. DATE OF BIRTH <u>Jan. 30 - 1872</u>		9. AGE (In years last birthday) <u>88</u> yrs		F UNDER 1 YEAR IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank S. Stehle</u>				14. MOTHER'S MAIDEN NAME <u>Mary Martha Lenney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>Mrs. Frank C. Maley, 105 Southbrook Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>450.0</u> DUE TO <u>Cardiac thrombosis</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO <u>Coronary atherosclerosis</u> (b) <u>Coronary atherosclerosis</u> (c) <u>Coronary atherosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bethesda, Md.</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1939</u> to <u>23 Jan. 1961</u> that (I) (we) last saw the deceased alive on <u>23 Jan. 1961</u> and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. Aud</u>				22b. ADDRESS <u>9006 Colesville Road, Silver Spring, Md.</u>			
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>				22d. ADDRESS <u>9006 Colesville Road, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		23d. LOCATION (City town or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond D. Ziska</u>				25a. REC'D BY REGISTRAR <u>JAN 26 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

873

CERTIFICATE OF DEATH

60866

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>8236 14th Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Handman</u> Middle 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Merchandise</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>		4. DATE OF DEATH Last <u>1</u> Month <u>15</u> Day <u>1961</u> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>	
13. FATHER'S NAME <u>Reuben Landman</u> 14. MOTHER'S MAIDEN NAME <u>MELAMID</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>Hospital Records</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, terminal</u> (b) <u>Emphysema</u> (c) <u>Chronic bronchitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 years to the first disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11-15</u> p.m. <u>1961</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town, (County) (State) <u>Hyattsville, Prince George's County, Maryland</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1955</u> to <u>January 15, 1961</u> that (I) (we) last saw the deceased alive on <u>January 15, 1961</u> and that death occurred at <u>8:35 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Jason Geiger</u> 22c. PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u> 22d. ADDRESS <u>1111 Spring Street, Silver Spring, Md.</u> 22e. DATE SIGNED <u>1-15-61</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>1-16-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ONEVSHOLOM-TALMUD TORAH CEM. WASHINGTON, D.C.</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Danzansky & Sons - 3501-14th St NW</u> 25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> DATE <u>JAN 17 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



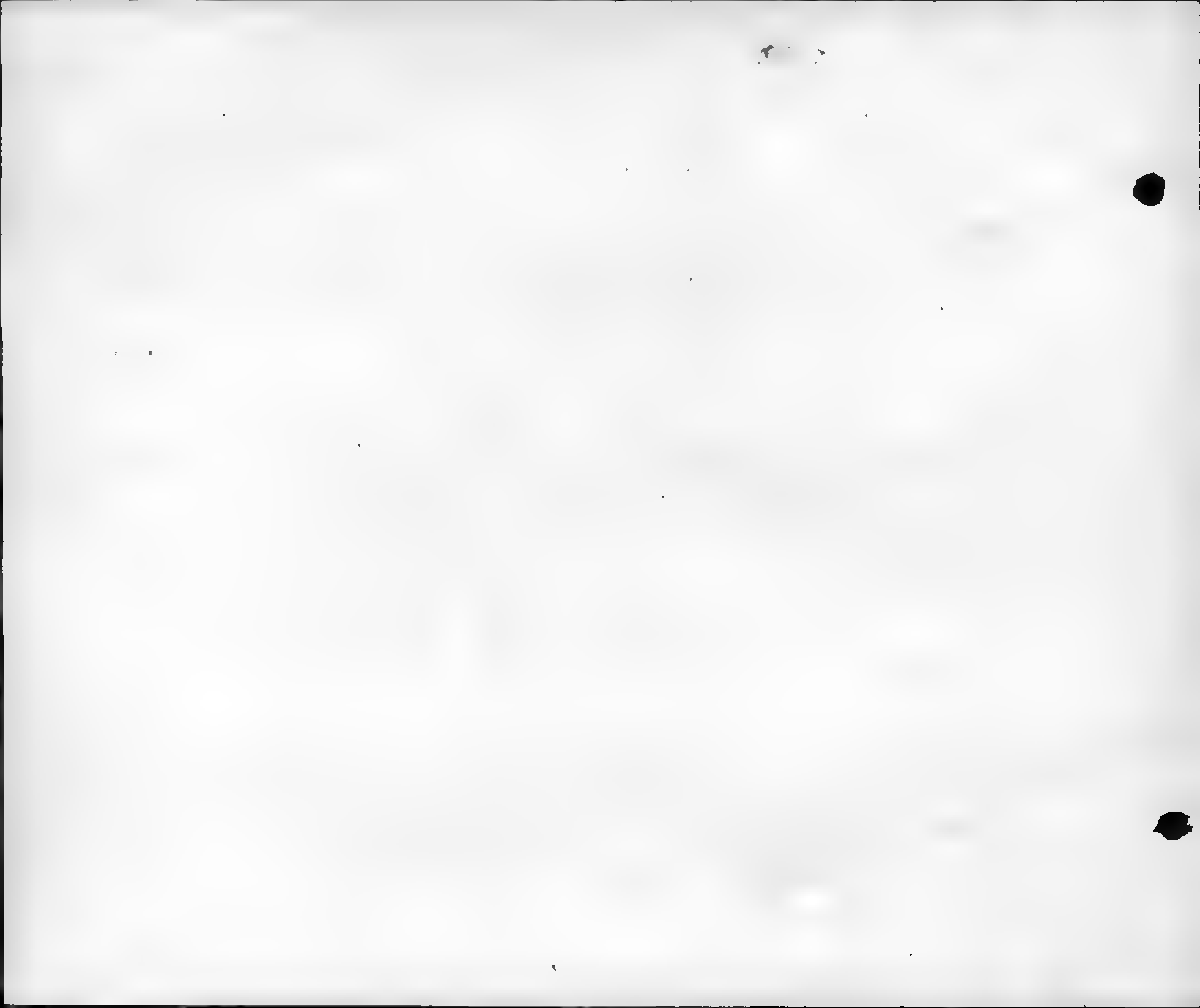
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

874

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60867

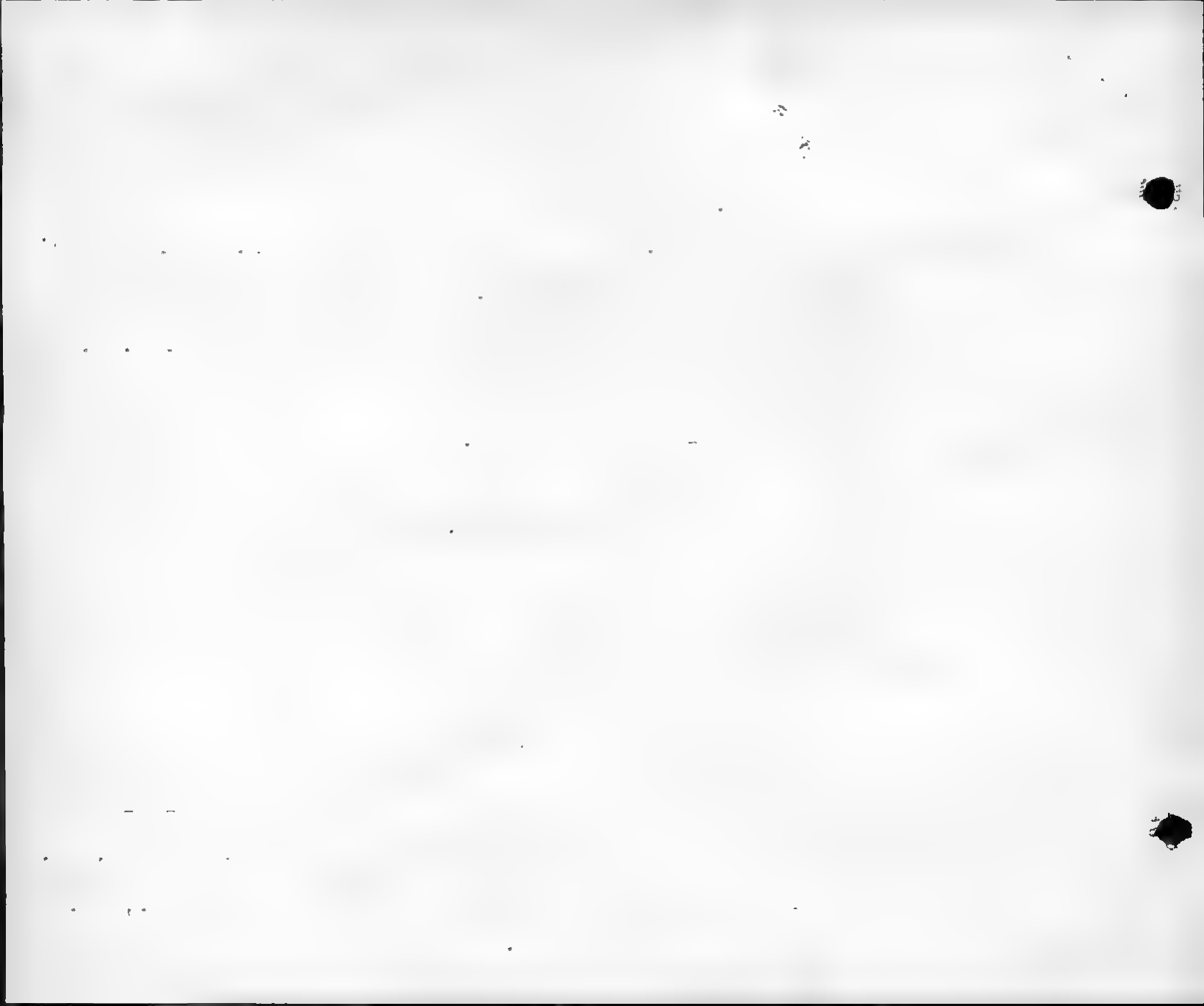
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN lb 10 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS Rt. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ACECE Middle ELIZABETH Last LEE				4. DATE OF DEATH Month JANUARY Day 18 Year 19 61			
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/10/92	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME BAKER SEDGWICK				14. MOTHER'S MAIDEN NAME LAURA POWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. RUPTURED ANEURYSM, THORACIC AORTA 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2. HEMOTHORAX (6000 cc) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to Jan 18 19 61 , that (I) (we) last saw the deceased alive on Jan 18 19 61 , and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE Richard A. Yates M.D.				22b. DATE SIGNED 1/19/61		22c. PHYSICIAN'S NAME (Type) RICHARD A. YATES, M. D.	
22d. ADDRESS OLNEY, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/22/61		23c. NAME OF CEMETERY OR CREMATORY Lt Pleasant Cemetery		23d. LOCATION (City, town, or county) (State) N orbeck, MD	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Summelen				ADDRESS Rockville, Md		25a. REC'D BY REG-STRAR JAN 26 '61	
						25b. REGISTRAR'S SIGNATURE William S. H. H.	



VR A15 (4)
15M 9/59

6868

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 11 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6200 Valley Rd.				d. STREET ADDRESS 6200 Valley Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle E. Last LEE				4. DATE OF DEATH Month Jan. Day 13, Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1900	
9. AGE (In years last birthday) 60 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Fairfax, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Lee				14. MOTHER'S MAIDEN NAME Crump			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-03-4080		17. INFORMANT Wife Sara E. Lee		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute coronary thrombosis DUE TO (b) Arteriosclerotic heart disease Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (c)							
INTERVAL BETWEEN ONSET AND DEATH 1/2 hr 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/17/60 to 1/13/61 , 19 61 , that (I) (we) last saw the deceased alive on 1/12/61 , 19 61 , and that death occurred at 3:45 M, from the causes and on the date stated above							
22a. SIGNATURE Robert N. Coale M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 1-13-61 SIGNED	
22c. PHYSICIAN'S NAME (Type) ROBERT N. COALE				22d. ADDRESS 4630 Montgomery Ave., Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 1-14-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.				25a. REC'D BY REGISTRAR DATE JAN 16 '61		25b. REGISTRAR'S SIGNATURE William S. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

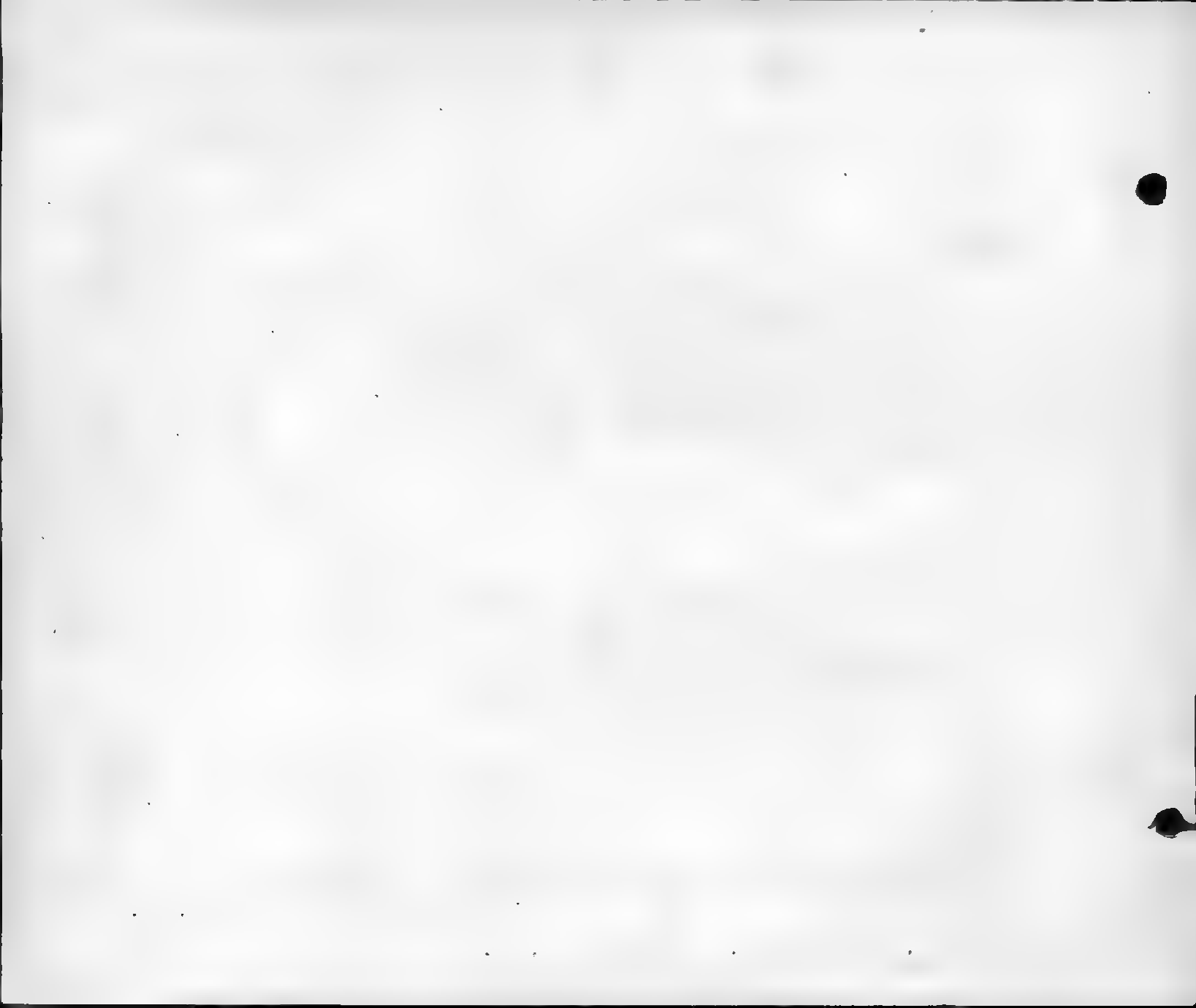
CERTIFICATE OF DEATH

Reg. Dist. No.

00869

376

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>20 yrs</i>		d. STREET ADDRESS <i>919 Gist Ave 1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>919 Gist Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Lucinda</i> Last <i>Leonard</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>3</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1877</i>
9. AGE (In years last birthday) <i>83</i> yrs		IF UNDER 1 YEAR: Months <i>8</i> Days <i>3</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James L. Green</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Daly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Daughter</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>44-2X</i> DUE TO <i>Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Heart Disease</i> (c) <i>Cardiac Hypertrophy</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i> <i>6 months</i> <i>1 yr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>sterility</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 24, 1960</i> , to <i>Jan 3, 1961</i> , that I last saw the deceased alive on <i>Jan 3, 1961</i> , and that death occurred at <i>7:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip E. Jones</i> M.D.		ADDRESS (Street, city or town, state) <i>918 Elsworth Drive</i> DATE SIGNED <i>1/3/61</i>	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>		<i>Silver Spring Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>1/7/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i> ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>Jan 11 '61</i>	24b. REGISTRAR'S SIGNATURE <i>C. S. S. Kiser</i>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

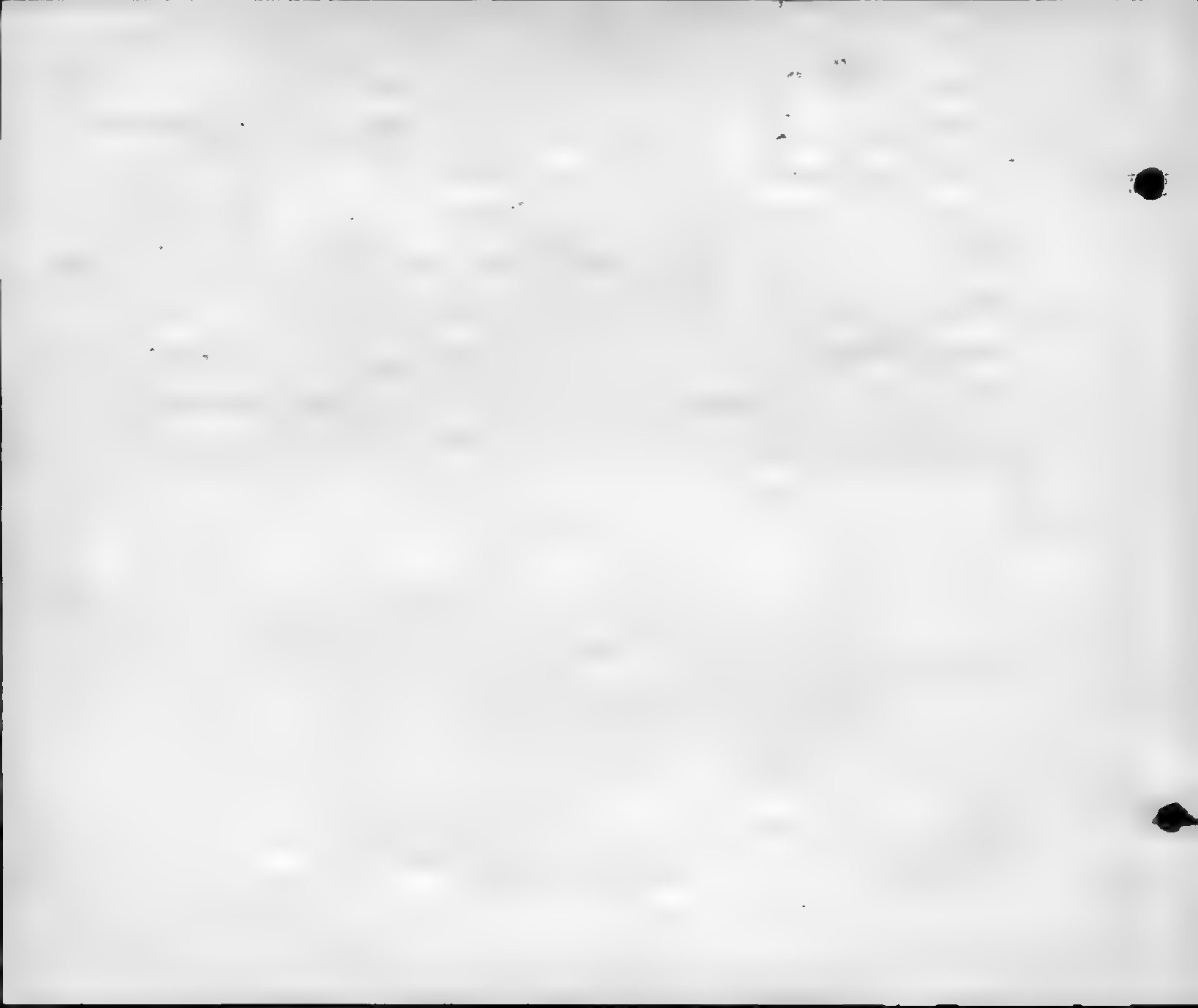
FOR STATE
HEALTH DEPT.

M

1

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)			
a. COUNTY				b. COUNTY			
Montgomery				Maryland			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Takoma Park				Takoma Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
Wash. San. & Hosp.				8219 Flower Ave.			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
Lewis Conrad Linkins				1 9 1961			
5. SEX				6. COLOR OR RACE			
Male				White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11-26-1890			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
Sheet Metal Worker				Washington D.C. American			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Frank Linkins				MacDonald			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
Yes 1917-1919				17. INFORMANT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. WAS AUTOPSY PERFORMED?			
PART I. DEATH WAS CAUSED BY:				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
IMMEDIATE CAUSE (a)				INTERVAL BETWEEN ONSET AND DEATH			
420.1				Sudden			
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year				20d. INJURY OCCURRED			
Hour a.m. p.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
19				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)			
(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER			
Frank J. Broschaut				ASSISTANT MEDICAL EXAMINER			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
FRANK J. Broschaut				DATE SIGNED			
1-9-61							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
Burial				Jan 12, 1961			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country)			
Arlington National Cemetery				Arlington, Virginia			
23. FUNERAL DIRECTOR				24. REC'D BY REGISTRAR			
J. Arthur Walters, 254 Carroll St NW DC				24b. REGISTRAR'S SIGNATURE			
				DATE JAN 11 '61			
				Charles S. Krause			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

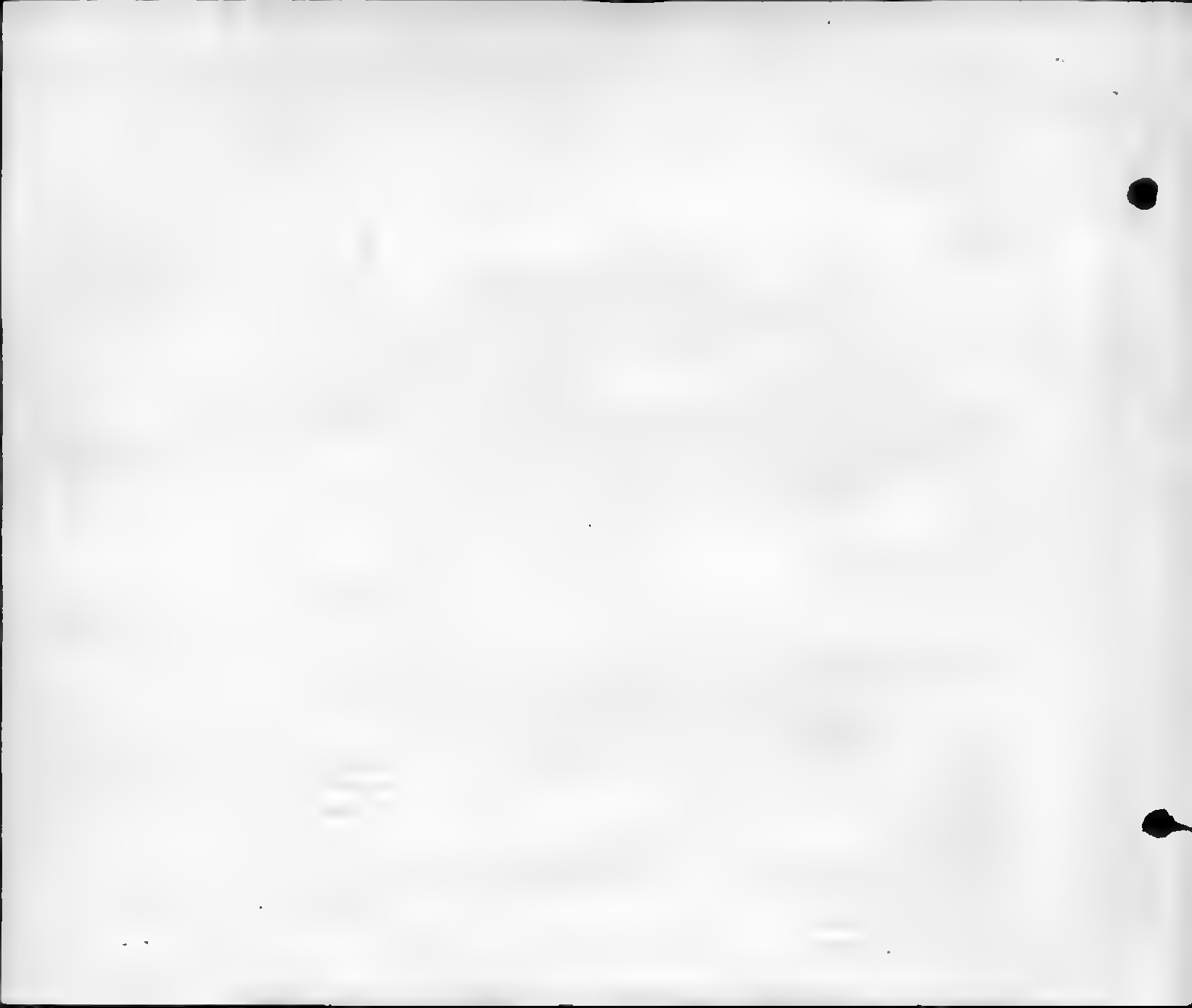
878

CERTIFICATE OF DEATH

Reg. Dist. No. 60876

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Gen Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington MD 41</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>9632 Kensington Plng 1</u>	
3. NAME OF DECEASED (Type or print) <u>George F. List</u>		4. DATE OF DEATH <u>Jan 4 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 JAN 1869</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER (R)</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSEPH</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN ELIZABETH REINSTEIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>567-22-2915A</u>	
17. INFORMANT <u>CDR H.M. KALSTAD</u>		Address <u>KENSINGTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>None 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/16, 1960</u> , to <u>present</u> , that I last saw the deceased alive on <u>1/3, 1961</u> , and that death occurred at <u>9:25 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhan</u>		ADDRESS (Street, city or town, state) <u>8805 Conn Ave</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAN</u>		DATE SIGNED <u>1/4/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>1/4/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JAN 6 61</u>		24b. REGISTRAR'S SIGNATURE <u>James L. Thoms</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

879 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60872

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6005 Gloster Rd</u>		d. STREET ADDRESS <u>6005 Gloster Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Philip R. Lockwood</u>		4. DATE OF DEATH <u>Jan 18 1961</u>	
5. SEX <u>Male</u>		6. DATE OF BIRTH <u>6-9-46</u>	
6. COLOR OR RACE <u>White</u>		7. AGED years <u>14</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Junior High Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Ralph B. Lockwood</u>		14. MOTHER'S MAIDEN NAME <u>Florence Johnston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ralph B. Lockwood - Son</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 974X DUE TO <u>Hanging</u> Conditions, if any, which gave rise to immediate cause (b) <u>Hanging</u> (c) <u>Hanging</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>Asphyxia</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Asphyxia</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found hanging by neck in basement of home</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-05 p.m. 1-18 1961</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> or Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or country) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>JAN 23 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		24c. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de-
please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 18 Form 281 2- Maryland STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60873

- PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA
c. LENGTH OF STAY IN 1b 1 wk
NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Urban
- USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY 1
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 12220 Larkin Place
d. STREET ADDRESS 12220 Larkin Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
- NAME OF DECEASED (Type or print) Patricia Ann Lokey
4. DATE OF DEATH 1/26/61 Month 1 Day 26 Year 1961
- SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 12/22 1933
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 27 yrs. IF UNDER 1 YEAR Months 1 Days 1 IF UNDER 24 HRS. Hours 1 Min. 0
- 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Calif. 11. BIRTHPLACE (State or foreign country) U.S.A.
- FATHER'S NAME John Stauffer 14. MOTHER'S MAIDEN NAME Eleanor Rees
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 1 17. INFORMANT Husband (Charles Lokey) Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.2 Acute myocardial insufficiency
DUE TO (b) Myocarditis
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Collapsed while shoveling snow
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
- 20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
- ACTUAL SIGNATURE Frank J. Brochart M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Frank J. Brochart ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED 1-27-61
DEPUTY MEDICAL EXAMINER ☐ Address (Street, city, town, or county) _____
- 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/31/61 22c. NAME OF CEMETERY OR CREMATORY Arlington National 22d. LOCATION (City, town, or country) (State) Arlington, Virginia
23. FUNERAL DIRECTOR Tyson Wheeler Funeral Home ADDRESS 1331 E. Montgomery Avenue, Rockville, Md. 24a. REC'D BY REGISTRAR JAN 30 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

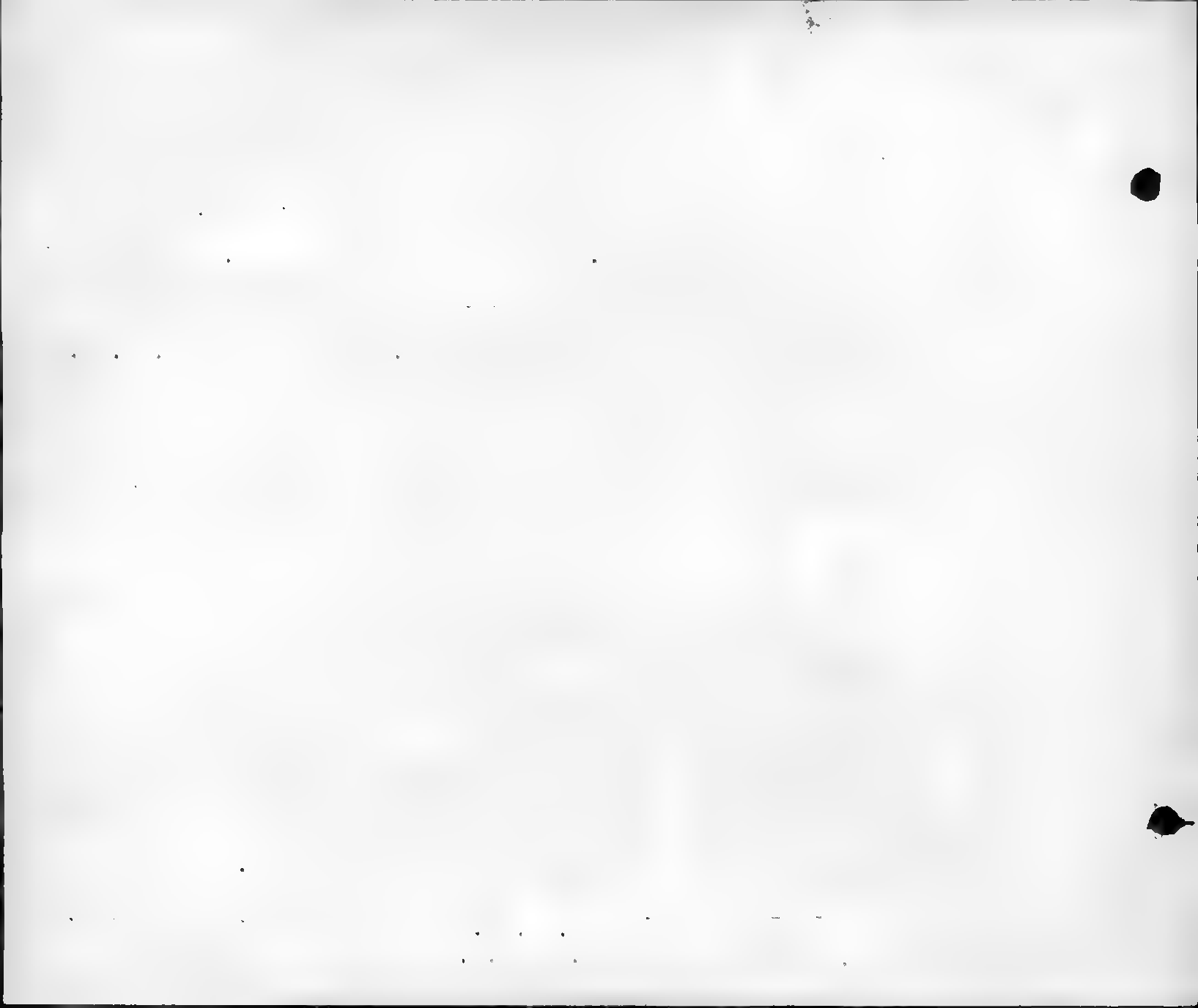
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66874

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived) f. Institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SILVER SPRING</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>10 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>727 EASLEY STREET</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
				d. STREET ADDRESS <u>727 EASLEY STREET</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILFRED</u> Middle <u>S.</u> Last <u>BLANCH</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-67</u>		9. AGE (In years last birthday) <u>92</u> yrs	10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSULTEE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>WILFRED S. BLANCH</u>				14. MOTHER'S MAIDEN NAME <u>WILHELMINE BLANCH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO <u>NO</u>		17. INFORMANT <u>WILFRED S. BLANCH</u> Address <u>SILVER SPRING</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) arteriosclerosis (2) Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>1-3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>1961</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>11 Jan 1961</u> , that (I) (we) last saw the deceased alive on <u>10 Jan 1961</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. And</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>1/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM D. AND</u>				22d. ADDRESS <u>2006 Colesville Rd. Silver Spring</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>1st. CLAYTON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Collins</u> ADDRESS <u>WASH. D. C.</u>				25a. REC'D BY REGISTRAR <u>DATE JAN 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

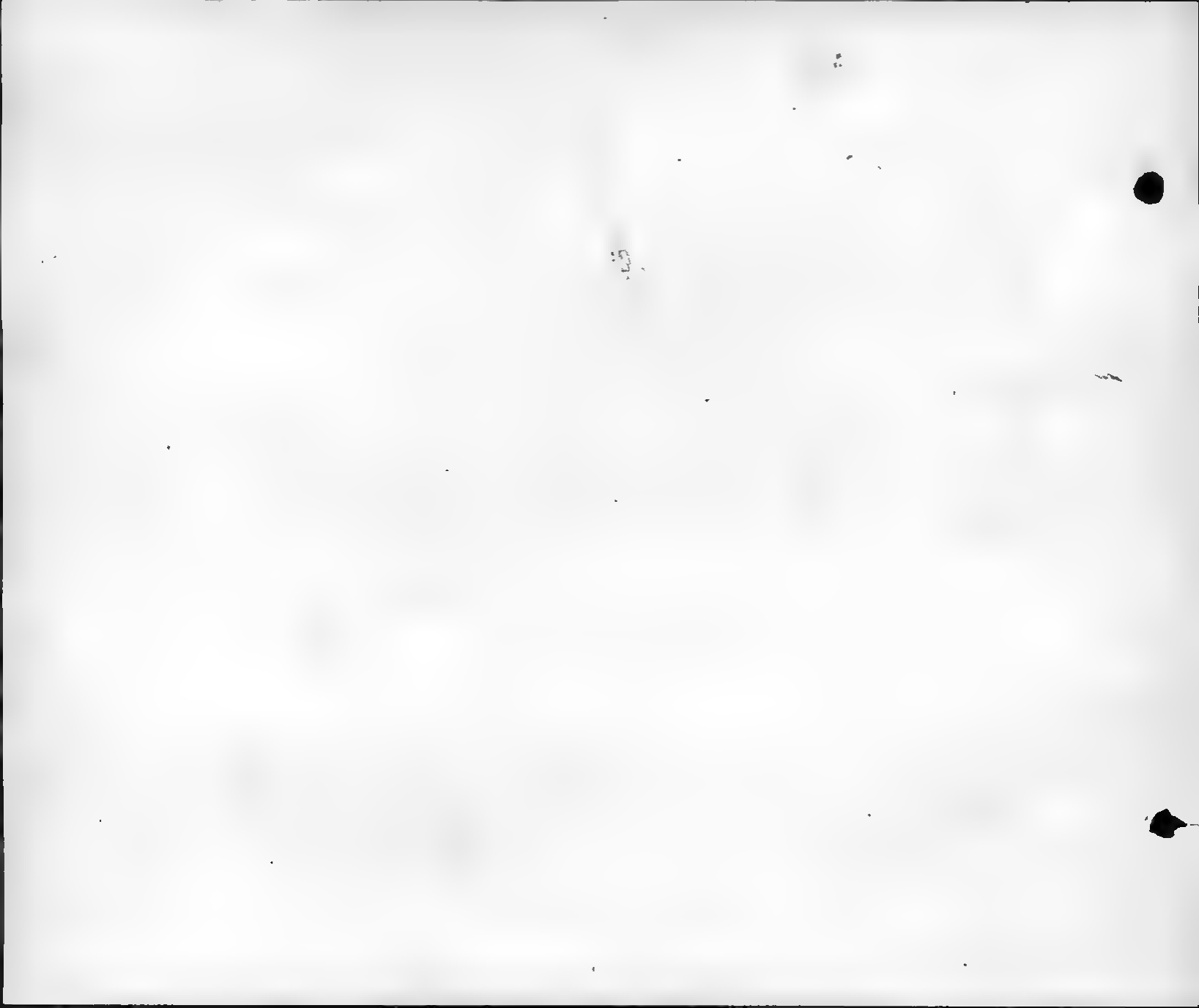


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MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALL AND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE 1662-2			
c. LENGTH OF STAY IN 1b 11/27/60 - 1/23/61				d. STREET ADDRESS 4106 GALLATIN ST			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FALL AND NURSING Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alline Middle F. Last LYNHAM		4. DATE OF DEATH Month 1- Day 23 Year 1961					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 16 1874	9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months 1 Days 23 Hours 19 Min.	IF UNDER 24 HRS Months 1 Days 23 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHARLES LYNHAM				14. MOTHER'S MAIDEN NAME Debra O'Connell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO NONE		17. INFORMANT Name Lucy A Lynham Address Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the sigmoid 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 yr							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Nov 1 1960 to Jan 23 1961 , that (I) (we) last saw the deceased alive on 1-21 1961 , and that death occurred 1-23 1961 M, from the causes and on the date stated above.							
22a. SIGNATURE Leonard Hays		22b. DATE SIGNED 1-23-61		22c. PHYSICIAN'S NAME (Type) Leonard Hays			
22d. ADDRESS Hyattsville, Md.							
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 26, 1961	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City, town, or county) (State) Washington D C				
24. FUNERAL DIRECTOR'S SIGNATURE R. Gasch's Sons Hyattsville Md.			25a. REC'D BY REG STRAR JAN 26 61		25b. REGISTRAR'S SIGNATURE C. J. 98 Hays		



1
FOR STATE
HEALTH DEPT.

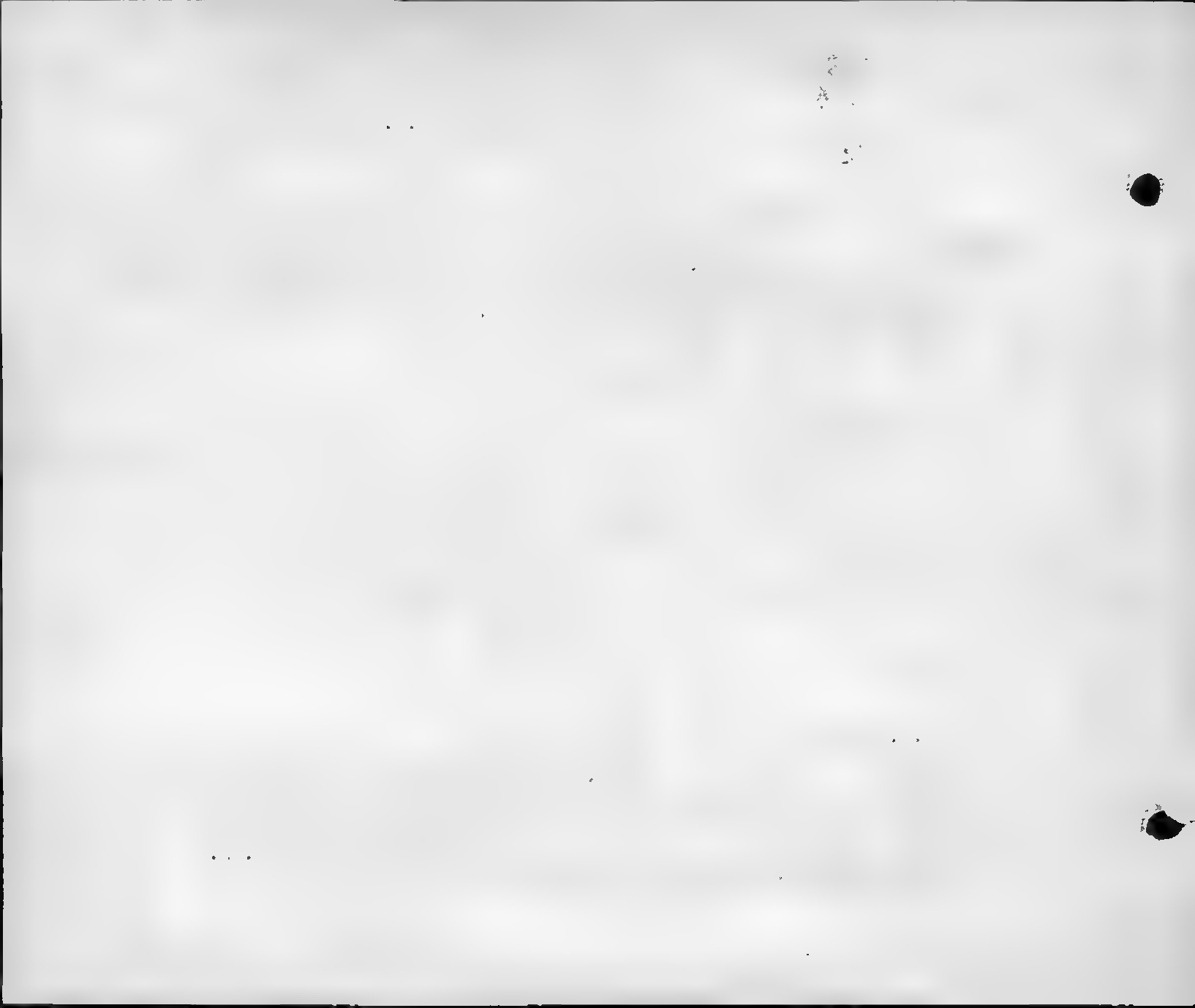
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
883 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00876

1. PLACE OF DEATH • COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		e. STREET ADDRESS 4110 Fessenden St. N.W.	
3. NAME OF DECEASED (Type or print) Florence P. Mac Donald		4. DATE OF DEATH Jan. 12 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 2 1891	
9. AGE (in years) (If UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) Months Days Hours Min. 69 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.A	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. BIRTHPLACE (State or foreign country) Wash. D.C	
13. FATHER'S NAME Gerald Piper		14. MOTHER'S MAIDEN NAME Minnie Duetch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Daughter Mrs. Allen Minnix Jr. (Same as Item 2)	
17. INFORMANT Daughter Mrs. Allen Minnix Jr. (Same as Item 2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Subdural Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pontine Hemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall on floor at home	
20c. TIME OF INJURY Month, Day, Year 7 A.M. 1-10-61		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Wash. D.C	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Brochart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Brochart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/61	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cems.		22d. LOCATION (City, town, or country) (State) Bladensburg, D.C. Md.	
23. FUNERAL DIRECTOR Chung Chase Funeral Home		24a. REC'D BY REGISTRAR JAN 18 '61	
ADDRESS 5103 2nd St. N.W.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



884

CERTIFICATE OF DEATH

Reg. Dist. No.

68877

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRETT PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRETT PARK (BETHESDA)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Georgetown Preparatory School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) REV KELVIN T. MACKANAVACH		4. DATE OF DEATH Jan / 5 / 19 61	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20 1907
9. AGE (in years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest		10b. KIND OF BUSINESS OR INDUSTRY Religious	
11. BIRTHPLACE (State or foreign country) Nova Scotia		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME Thomas MacKavanagh		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO —	
17. INFORMANT Religious House Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Thrombosis (c) Coronary Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 hr. Indefinite	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/1/1960 , to 1/5/61 , that I last saw the deceased alive on 1/5/1961 , and that death occurred at 5:00 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington D.C. DATE SIGNED 1/5/61			
ACTUAL SIGNATURE Stephen T. James M.D. Washington, D.C.		PHYSICIAN'S NAME (Type) Stephen T. James	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-9-61	
22c. NAME OF CEMETERY OR CREMATORY Georgetown College Cem		22d. LOCATION (City, town or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE St. Don. DeVol ADDRESS 2224 Wisc Ave		24a. REC'D BY REGISTRAR DATE JAN 17 '61	
24b. REGISTRAR'S SIGNATURE Curtis E. Hume			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

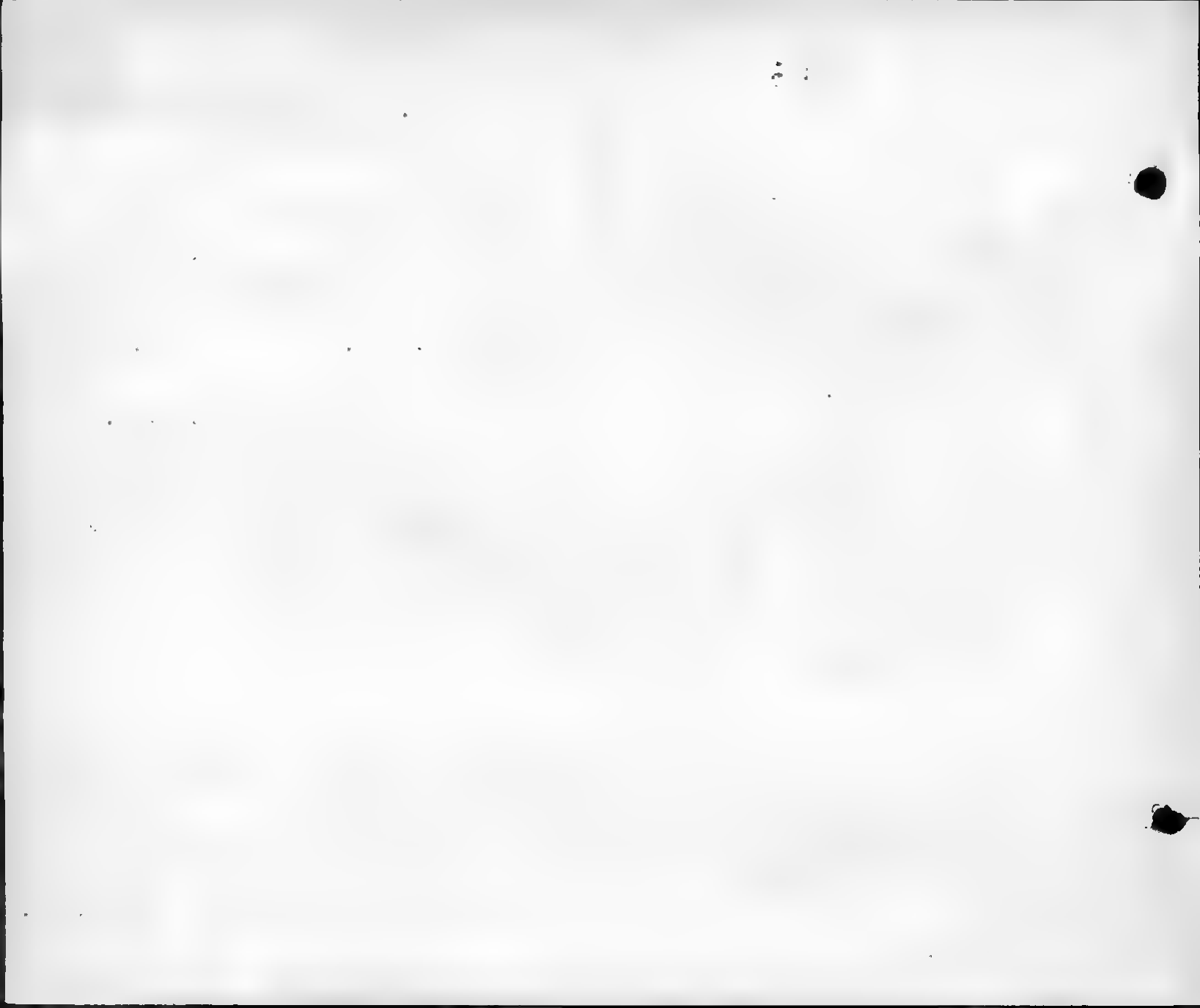
CERTIFICATE OF DEATH

68878

885

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 10 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2206 Hildarose Drive				d. STREET ADDRESS 2206 Hildarose Drive			
3. NAME OF DECEASED (Type or print) First Mildred Middle A. Last Maresch				4. DATE OF DEATH Month Jan Day 22 Year 1961			
5 SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/11/1899	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR: Months 61 Days 61 Hours 61 Min 61		IF UNDER 24 HRS: Months 61 Days 61 Hours 61 Min 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Duluth, Minn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frederick C. Ehling				14. MOTHER'S MAIDEN NAME Cora Mae Shattuck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO no		17. INFORMANT Anthony Maresch Address: S.S., Md. 2206 Hildarose Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous Pleural Effusion DUE TO (b) Carcinoma of Right Breast & Metastasis To Lung & Skin DUE TO (c) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH 4 weeks 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 9, 1961 to Jan 22, 1961 that (I) (we) last saw the deceased alive on Jan 21, 1961 , and the death occurred at 1:00 PM from the causes and on the date stated above.							
22a. SIGNATURE William Frank				22b. DATE SIGNED Jan 22, 1961			
22c. PHYSICIAN'S NAME (Type) WILLIAM FRANK, M.D.				22d. ADDRESS 544 W. MONTGOMERY AVE ROCKVILLE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/25/1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				25a. REC'D BY REGISTRAR DATE JAN 25 '61		25b. REGISTRAR'S SIGNATURE Robert S. Hines	

HOSPITAL CERTIFICATION: This law requires that the death certificate be executed within 24 hours of death. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

886

00879

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>571 University Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian Wallace Marsh</u> First Middle Last		4. DATE OF DEATH Month <u>Jan.</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Cauc.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-27-70</u> 9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Builder</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> 11. BIRTHPLACE (County & State or foreign country) <u>Massachusetts</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Marsh</u> 14. MOTHER'S MAIDEN NAME <u>Abbie Greene</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>Mr. Burton W. Marsh</u> Address <u>Son, 326 Rittenhouse St., Washington, D.C.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Compensatory heart failure</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u> 20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20d. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 13, 1961</u> , to <u>Jan 22, 1961</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Jan 22, 1961</u> , and that death occurred at <u>8:20</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Eino Magi</u> 22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22b. DATE SIGNED <u>1/22/61</u> 22d. ADDRESS <u>918 Univ. Blvd. E., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>JAN, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>HOPE CEMETERY</u> 23d. LOCATION (City, town or county) <u>Worcester, Worcester Co., Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Harris</u> 25a. REC'D BY REGISTRAR <u>DATE JAN 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION



887

CERTIFICATE OF DEATH

Reg. Dist. No.

00880

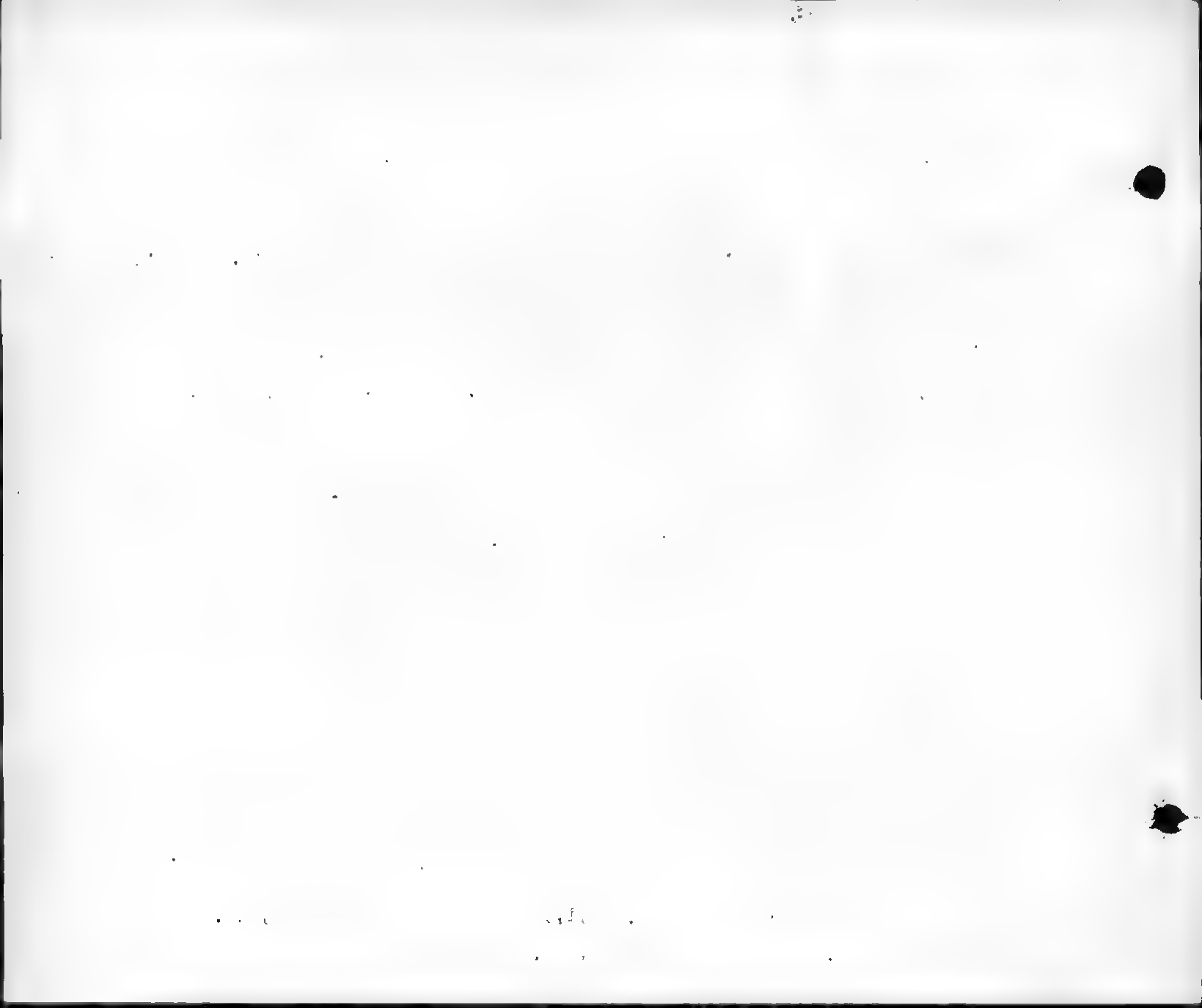
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kearsonville (RURAL)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kearsonville (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>MASON</u> Last <u>MASON</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1961</u>		
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1894</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Unknown</u>		
14. MOTHER'S MAIDEN NAME <u>Harriet Hebron</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		
16. SOCIAL SECURITY NO.			INFORMANT Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET OF DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Left hemiplegia</u>				<u>30 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u>				<u>12 years</u>	
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>15 Nov</u> , 19 <u>58</u> , to <u>Jan 20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 2</u> , 19 <u>61</u> , and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John Lawrence</u> M.D.				DATE SIGNED <u>1/20/61</u>	
PHYSICIAN'S NAME (Type) <u>P.O. Boyd</u>				<u>MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/26/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>	
22d. LOCATION (City, town, or county) <u>Sugarland, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Anderson</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 1 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>William J. King</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

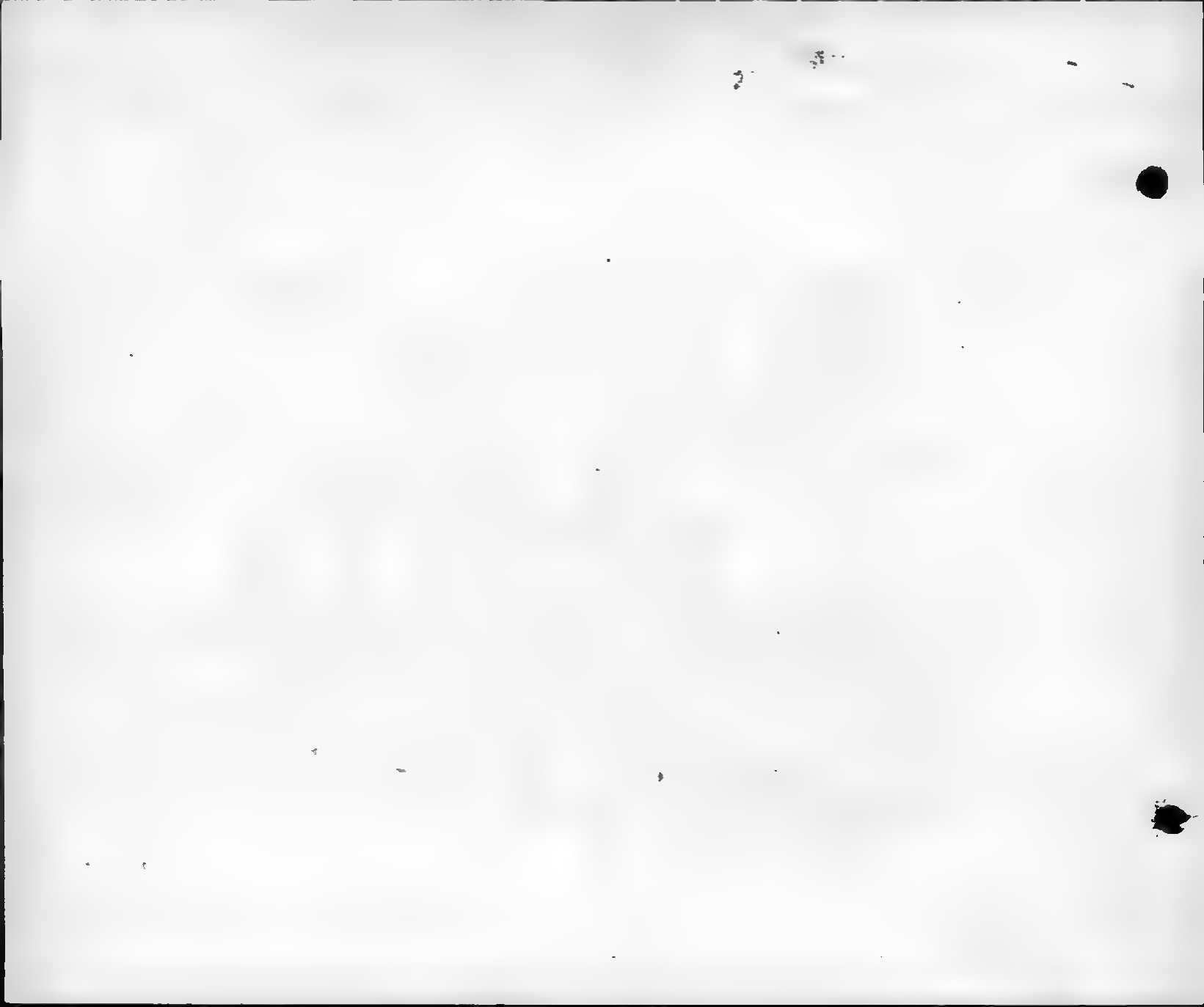


388

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

68881

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 47 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5308 Huntington Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARA L. MAST		4. DATE OF DEATH Month Day Year Jan. 3, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1879
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months 1 Days 1	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Church Organist		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Henry		14. MOTHER'S MAIDEN NAME Margaret Lane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Son Address 18 Nod Rd., Ridgefield, Conn.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Viral Gastroenteritis		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Possible myocardial infarction DUE TO 1 hour			
(c) atheriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial infarction 2 years ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1961 to Jan 2, 1961 , that (I) was last saw the deceased alive on Jan 2, 1961 , and that death occurred at 7 A.M. from the causes and on the date stated above			
22a. SIGNATURE Edward W. Youngblood		22b. DATE SIGNED Jan 3, 1961	
22c. PHYSICIAN'S NAME (Type) Edward W. Youngblood		22d. ADDRESS 8606 Ewing Drive, Bethesda, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 1-5-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR JAN 6 '61 DATE	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Carlton S. Frank	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

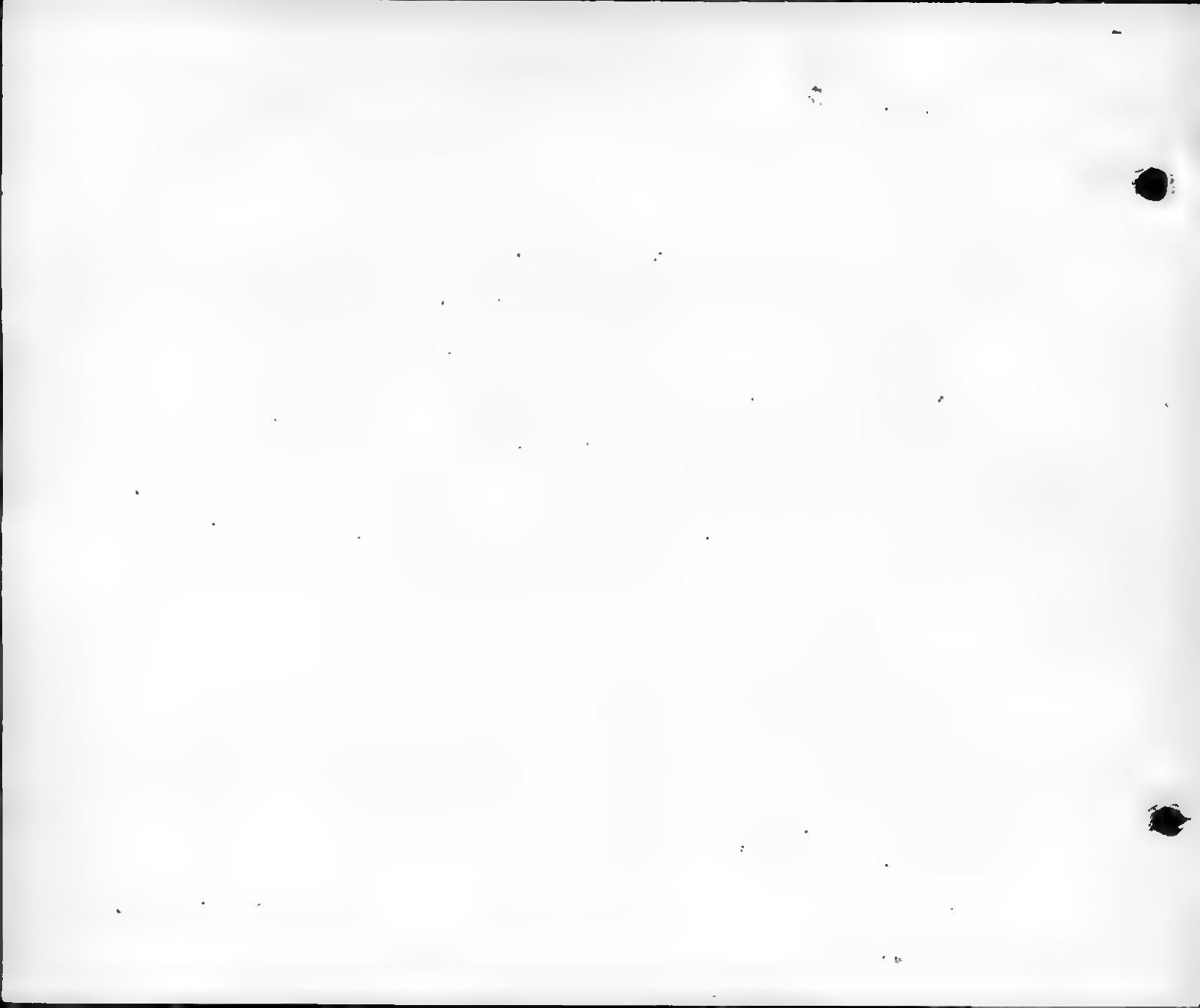
889

CERTIFICATE OF DEATH

Reg. Dist. No.

66882

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res. dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 Park St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>R.</u> Last <u>Mathers</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1923</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CIT. ZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Mathers</u>		14. MOTHER'S MAIDEN NAME <u>Louise Hedges</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>012-32 277</u>	
17. INFORMANT <u>William H. Mathers</u>		18. ADDRESS <u>102 Park St. Rockville, Md.</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2</u> DUE TO <u>Carotid arteriosclerosis - Pulmonary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Paralysis of Left femur</u> DUE TO <u>18 months</u> (c) <u>6 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>18 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 2, 1959</u> to <u>Jan 2, 1961</u> , that I last saw the deceased alive on <u>Jan 2, 1961</u> and that death occurred at <u>4:15 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.S. Murphy</u>		DATE SIGNED <u>Jan 2, 1961</u>	
PHYSICIAN'S NAME (Type) <u>W.S. Murphy</u>		ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/6/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>		24a. REC'D BY REGISTRAR <u>JAN 6 '61</u>	
ADDRESS <u>1331 E. Montgomery Ave., Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



890

CERTIFICATE OF DEATH

Reg. Dist. No.

00883

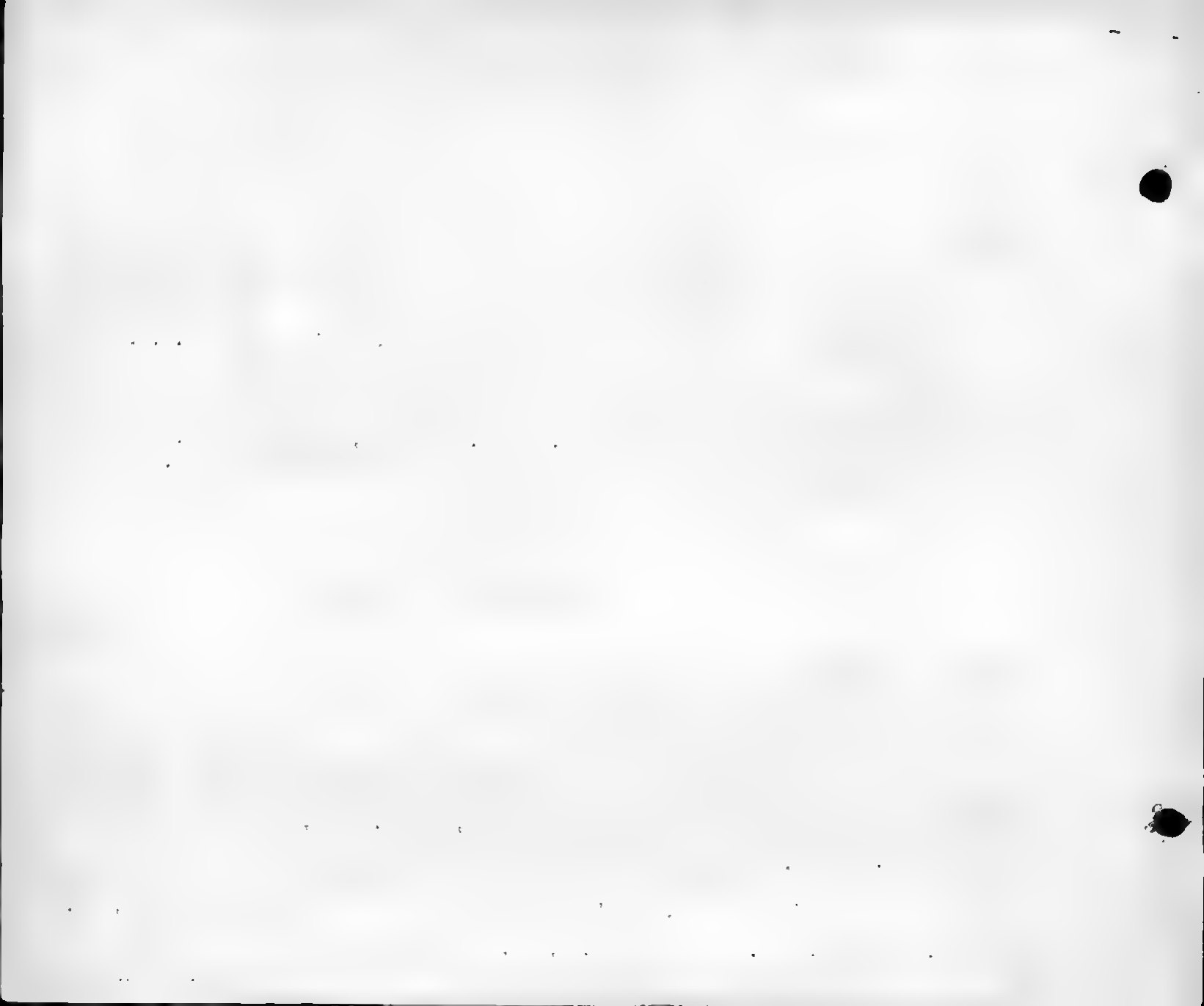
1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium, Hospital				d. STREET ADDRESS 1525 CREST ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) BRIAN First GERARD Middle McDonald Last				4. DATE OF DEATH Month 1 Day 8 Year 1961			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/6/10 5PM	
9. AGE (In years lost birthday) yrs 51		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 5 Hours 5 Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) TAKOMA PARK, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Leo William McDonald				14. MOTHER'S MAIDEN NAME DAUENHAUER Jean Patricia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMATION Address Mr. Leo W. McDonald, 1525 Crest Rd. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Atherosclerosis 7:25 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prima Fecunda DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 4/6 , 19 61 , to 4/8 , 19 61 , that I last saw the deceased alive on 1/8 , 19 61 , and that death occurred at 1:30 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10,620 Ga. Ave., DATE SIGNED 1/9/61							
ACTUAL SIGNATURE Herbert J. Jacobs				PHYSICIAN'S NAME (Type) HERBERT J. JACOBS			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/10/61		22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CATHOLIC CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC.				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JAN 12 61	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

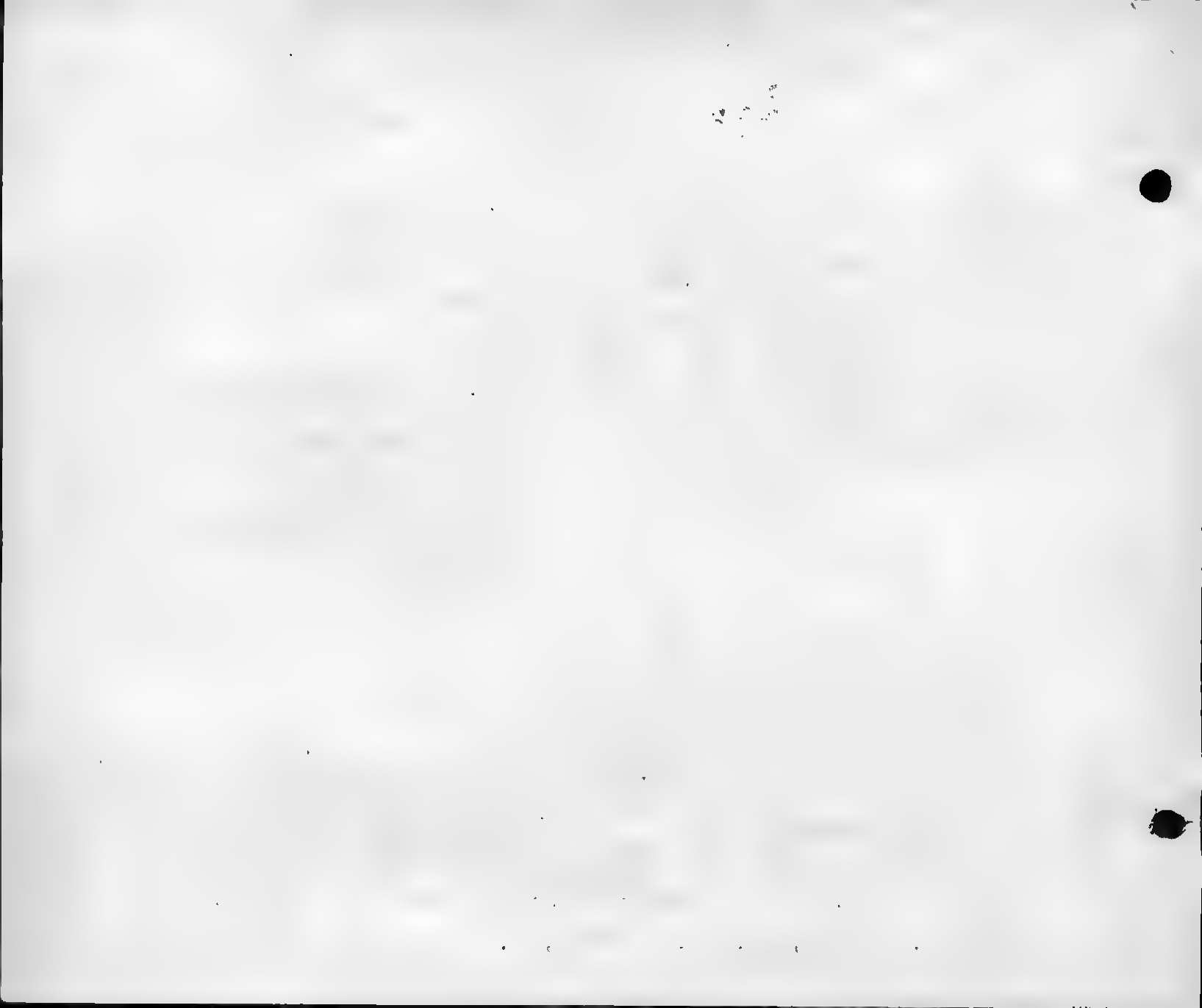
CERTIFICATE OF DEATH

891

66884

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hosp</u>		e. STREET ADDRESS <u>1307 DATE DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond CARROL McEaha</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-97</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>John W. McEaha</u>		14. MOTHER'S MAIDEN NAME <u>Hettie BRISLIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. 17. INFORMANT <u>p t hospital record.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>171-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a) <u>Carcinoma of Urinary Bladder</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>1/31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-31-1961</u> , and that death occurred at <u>7:55 P</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Hare</u>		22b. DATE SIGNED <u>2/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert H. Hare M.D.</u>		22d. ADDRESS <u>7600 Carroll Ave., Ti Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/4/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lovettsville Union Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Lovettsville, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



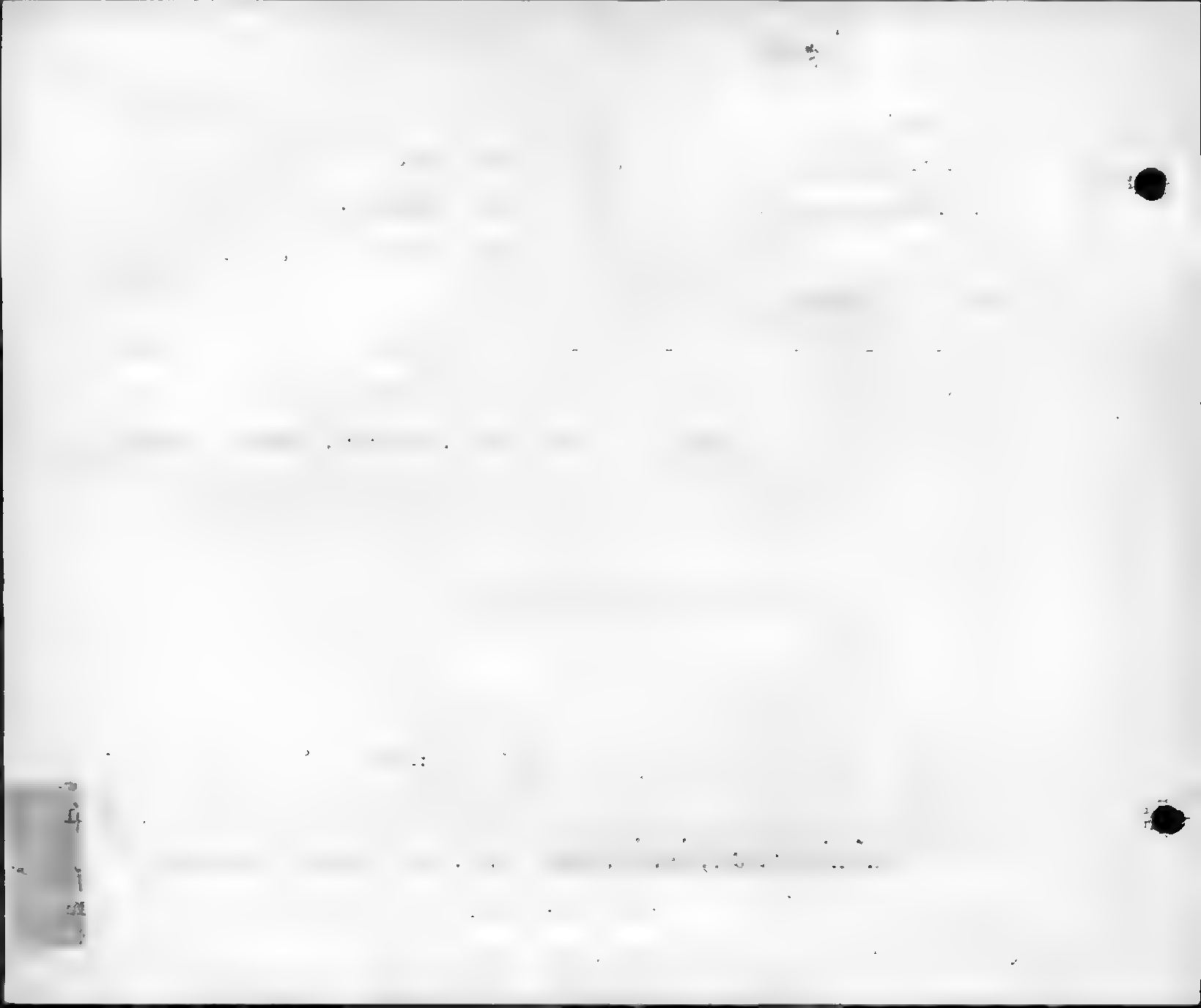
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

892

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00885

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Chas. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head d. STREET ADDRESS Apt. 6L, River View Village e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Kevin Middle MC GARRY Last MC GARRY		4. DATE OF DEATH Month January Day 21 Year 19 61		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-9-61		9. AGE (In years last birthday) yrs 12		IF UNDER 1 YEAR Months 12		IF UNDER 24 HRS Hours 12 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Edward R. McGarry								14. MOTHER'S MAIDEN NAME Lucilie Talbot									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO None				17. INFORMANT (f) Edw. R. McGarry, same as #2 above Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Volvulus, Small bowel obstruction DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) INTERVAL BETWEEN ONSET AND DEATH 12																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour 0 m p m 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)				20f. (City or town) (County) (State)					
21. I certify that he (this hospital) attended the deceased from Jan. 9 4:15 AM to Jan. 21 19 61 that he (we) last saw the deceased alive on Jan. 21 19 61 , and that death occurred at 4:15 AM , from the causes and on the date stated above																	
22a. SIGNATURE W. D. Hooper				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 1-21-61									
22c. PHYSICIAN'S NAME (Type) W. D. HOOPER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-24-61				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) (State) Arlington Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE Collins Funeral Home, 3821 14th St., NW, WashDC								25a. REC'D BY REGISTRAR DATE JAN 25 '61				25b. REGISTRAR'S SIGNATURE Arthur S. House					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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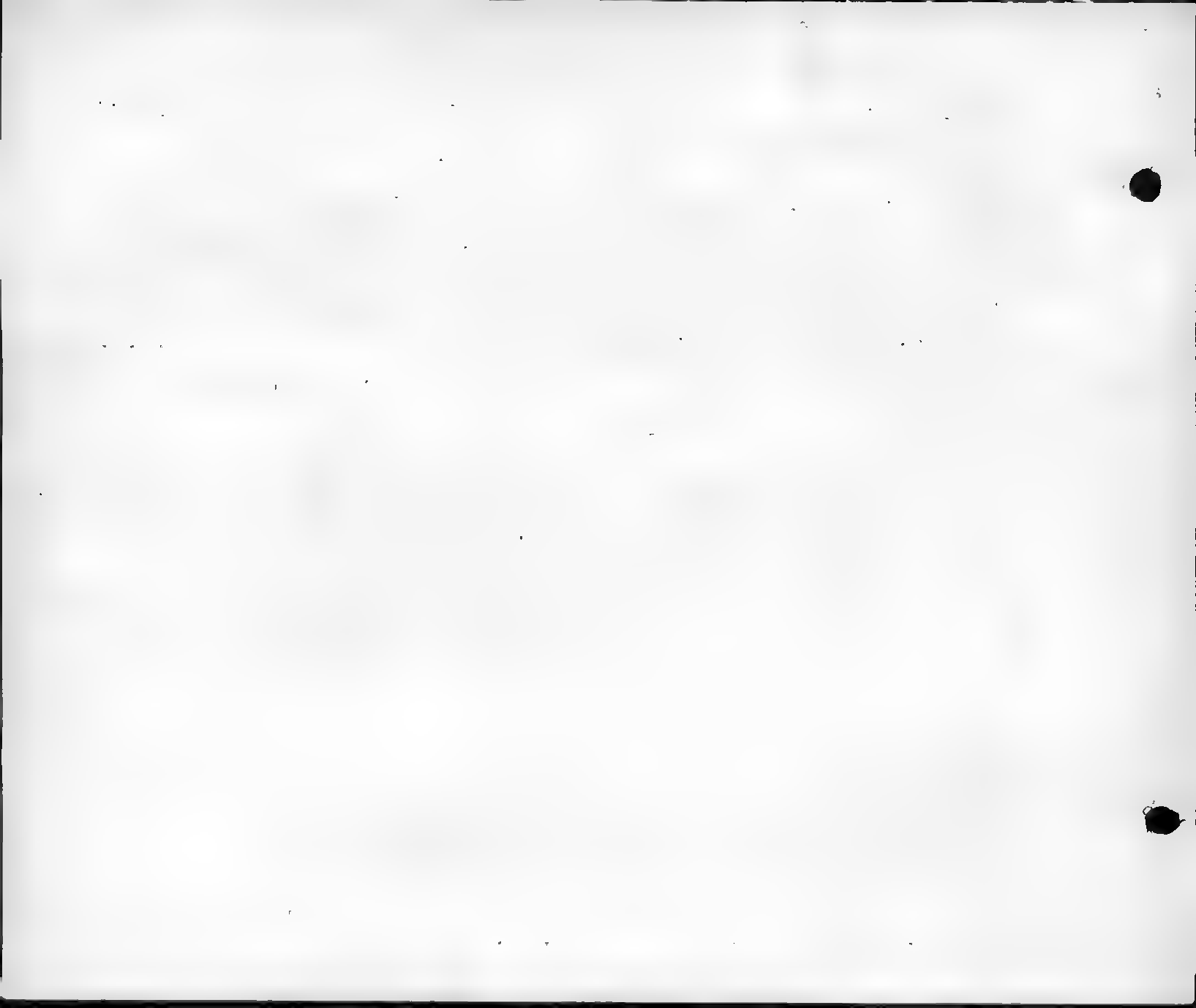
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

893

CERTIFICATE OF DEATH

60886

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 7 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				e. STREET ADDRESS 2000 Cedar Lane			
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Field Mc Laury				4. DATE OF DEATH Month Day Year January 23 19 61			
5 SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/1890	9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising Manager		10b. KIND OF BUSINESS OR INDUSTRY Railroads		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Henry Mc Laury				14. MOTHER'S MAIDEN NAME Nellie Murdock Washburn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 718-10-7499		17. INFORMANT hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma left lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Metastases to Rt. lung, liver, kidney (c) and lymph nodes.							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above							
22a. SIGNATURE A. D. Bonifant				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT				22d. ADDRESS Freely Spring Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/27/61		23c. NAME OF CEMETERY OR CREMATORY WOODSIDE CEMETERY		23d. LOCATION (City, town, or county) (State) BRINKLOW, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Jaska				25a. REC'D BY REGISTRAR DATE JAN 31 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

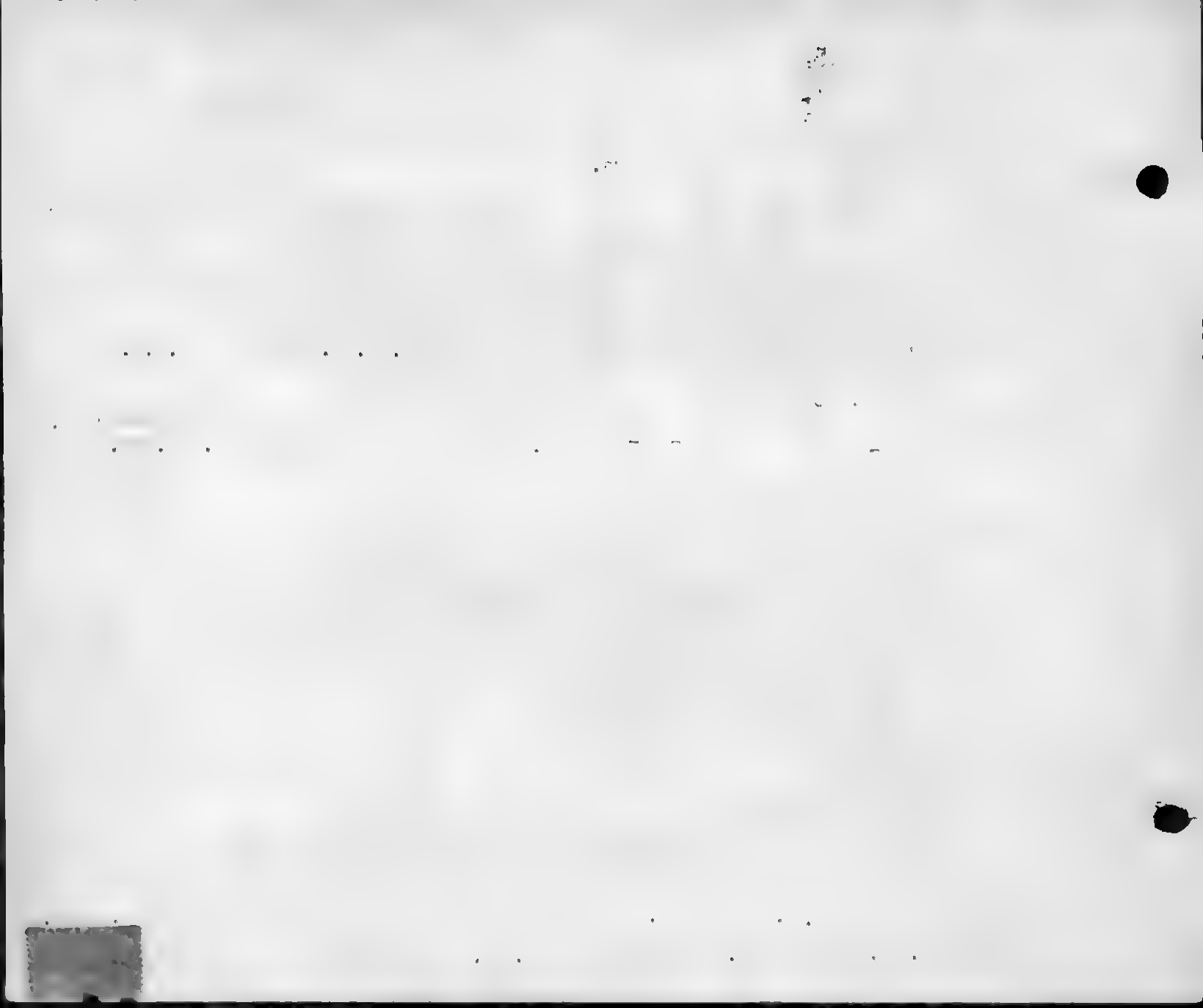
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

894

60887

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>6 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission only) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4330 Chesapeake St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Milton McQueen</u>		4. DATE OF DEATH <u>January 30, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/11/1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. AGE (In years last birthday) <u>80</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James C. McQueen</u>		14. MOTHER'S MAIDEN NAME <u>Sally Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-10-2961</u>	
17. INFORMANT <u>Mrs. Mary Barrow (daughter)</u>		Address <u>5516 Center St., Ch. Ch. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO		19. INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Congestive heart failure due to coronary artery disease</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 30, 1961</u> to <u>Jan 30, 1961</u> that (I) (we) last saw the deceased alive on <u>Jan 30, 1961</u> and that death occurred at <u>4:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George A. Gray, Jr.</u>		22b. DATE SIGNED <u>1/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr.</u>		22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 1, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>JAN 31 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			



895

CERTIFICATE OF DEATH

Reg. Dist. No.

1.08884

1. PLACE OF DEATH a. COUNTY MONTGOMERY	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D.		b. COUNTY WASHINGTON, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	c. LENGTH OF STAY IN 1b 47	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.	d. STREET ADDRESS 6101-16th STREET - N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JACOB	First	Middle Meh/	Last man	4. DATE OF DEATH Month January Day 23 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 17, 1896	9. AGE (In years last birthday) 64 yrs	IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	10b. KIND OF BUSINESS OR INDUSTRY LIQUOR STORE	11. BIRTHPLACE (State or foreign country) RUSSIA	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME MORDECAI MEHLMAN	14. MOTHER'S MAIDEN NAME RACHEL ROSENBAUM	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 578-03-2469	INFORMANT Address FLORENCE F. MEHLMAN - 6101-16th ST. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) Hypertensive Cardiovascular Disease	INTERVAL BETWEEN ONSET AND DEATH 1 hr. 8 yrs	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. .19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1955 to Jan 22 , 1961, that I last saw the deceased alive on Jan 10 , 1961, and that death occurred at 1801 Eye St NW, Washington D.C. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Cyril A. Schulman M.D. 1/23	22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-25-61	22c. NAME OF CEMETERY OR CREMATORY George Washington Mem. Cem. Hyattsville	22d. LOCATION (City, town or county) (State) M.D.	23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY + SONS - 3501-14th ST NW
24a. REC'D BY REGISTRAR JAN 27 '61	24b. REGISTRAR'S SIGNATURE Cyril A. Schulman	24c. REGISTRAR'S SIGNATURE Cyril A. Schulman	24d. REGISTRAR'S SIGNATURE Cyril A. Schulman	24e. REGISTRAR'S SIGNATURE Cyril A. Schulman	24f. REGISTRAR'S SIGNATURE Cyril A. Schulman

TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4.

Dr. Frank Broschart. Notified
and approves my certification
Cognate Curriculum used
1/22/61.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

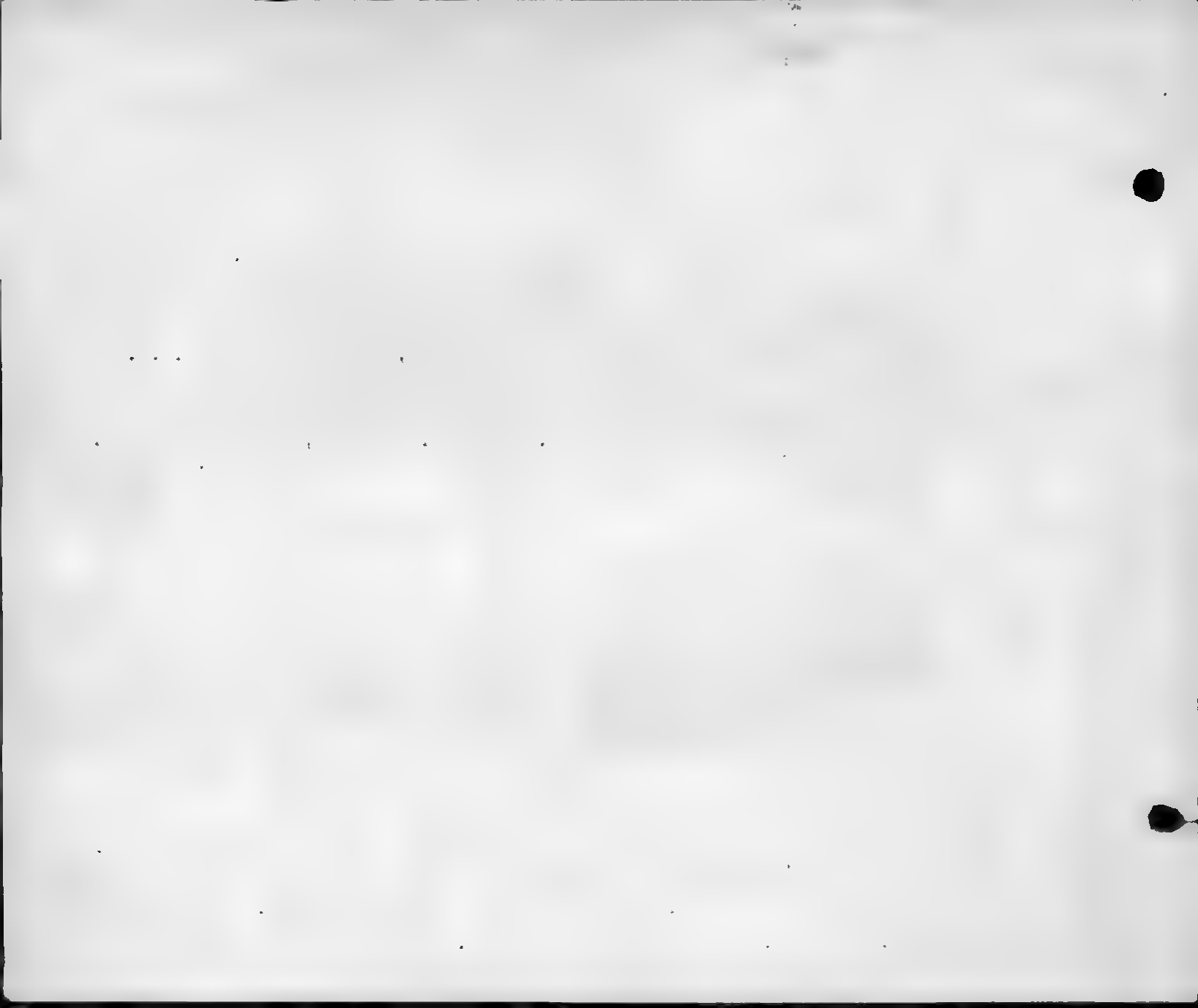
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

396 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60889

1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 208 DEARBORN AVENUE			d. STREET ADDRESS 208 DEARBORN AVENUE		
3. NAME OF DECEASED (Type or print) First Middle Last EMILY AMY MICHAELS			4. DATE OF DEATH Month Day Year JAN. 25 19 61		
5. SEX FEMALE			6. COLOR OR RACE WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 10/16/30 91		
9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min. 69 yrs.			10. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
11. BIRTHPLACE (State or foreign country) JERUSALEM, PALESTINE			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HARRY GARGOUR			14. MOTHER'S M.A.DEN NAME FREIDA unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT Mr. Edward C. Michaels, 208 Dearborn Ave. Silver Spring, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 423.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCART			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/25/61		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 1/26/61		
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY			22d. LOCATION (City, town, or country) (State) PRINCE GEO. COUNTY, MARYLAND		
23. FUNERAL DIRECTOR ADDRESS R. E. PUMPHREY, INC. SILVER SPRING, MD. Raymond W. Joka			24a. REC'D BY REGISTRAR DATE JAN 31 '61		
24b. REGISTRAR'S SIGNATURE Arthur E. Funnell					



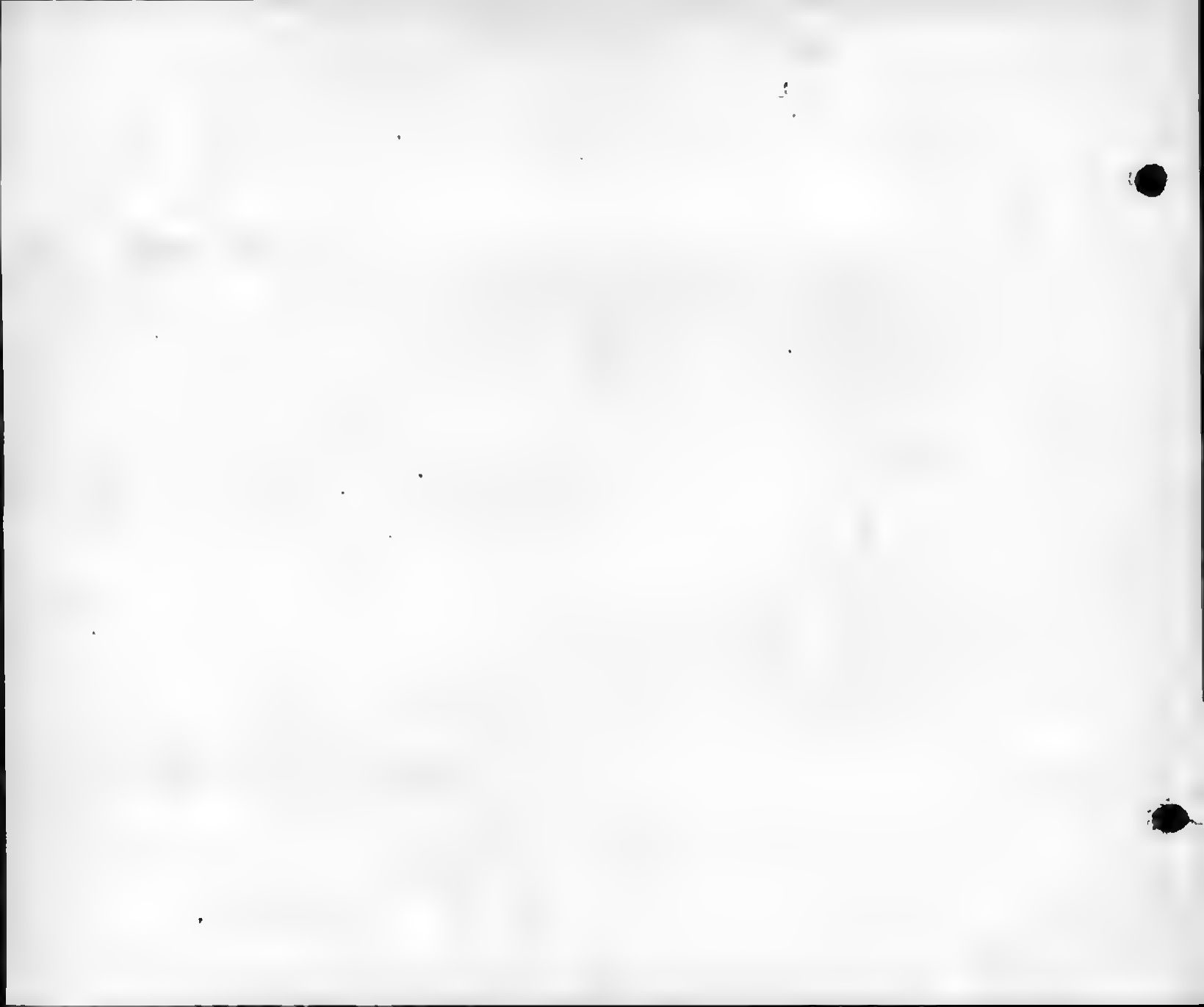
may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

897

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66890

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Irene</u> First Middle Last <u>miles</u>		4. DATE OF DEATH <u>Jan. 24</u> Month Day Year <u>1961</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/22</u> AGE (In years last birthday) <u>38</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Tubing Co. operator</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>	
13. FATHER'S NAME <u>Leitze Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Miles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO. <u>414-16-5285</u>	
17. INFORMANT <u>George H. Miles #2 above</u>		Address <u>#2 above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> <u>541.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Perforated Duodenal Ulcer</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>40 hrs</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> 19 <u>61</u> to <u>1/24</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> 19 <u>61</u> , and that death occurred <u>24</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Wm. R. Moses</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wm. R. Moses</u>		22d. ADDRESS <u>1835 Eye St N.W. (D.C.)</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>1-27-61</u>	<u>Arlington National</u>	<u>Arlington, Va.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u> ADDRESS <u>317 Pa. Ave. S.E. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 26 '61</u>	25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

898

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00891

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>#8 Crescent Place</i>				d. STREET ADDRESS <i>#8 Crescent Place</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>HARRY</i> Middle <i>H.</i> Last <i>MILLARD</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>17</i> Year <i>1961</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 8, 1897</i>	
9. AGE (In years last birthday) <i>63</i> yrs.		10. IF UNDER 1 YEAR Months <i>63</i> Days <i>17</i> Hours <i>17</i> Min <i>17</i>		11. IF UNDER 24 HRS Months <i>63</i> Days <i>17</i> Hours <i>17</i> Min <i>17</i>			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attorney</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Law Practice</i>			
11. BIRTHPLACE (State or foreign country) <i>OKLA.</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Henry H. Millard</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Miller</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>W.W.I.</i>			
17. INFORMANT <i>Louis A. Millard</i>				Address <i>Tulsa, Okla.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> 420.1 DUE TO <i>Coronary Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Heart Disease</i> DUE TO (c) <i>Coronary Heart Disease</i>							INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>2 years</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <i>Jan</i> Day <i>19</i> Year <i>1961</i> Hour <i>5</i> a.m. <i>17</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <i>1946</i> to <i>17 Jan</i> , 1961, that (I) (we) last saw the deceased alive on <i>5 Jan</i> , 1961, and that death occurred at <i>12:15</i> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>H B Queen</i> M.D.				22b. DATE SIGNED <i>17 Jan 1961</i>			
22c. PHYSICIAN'S NAME (Type) <i>H B QUEEN M.D.</i>				22d. ADDRESS <i>7112 Willow Ave Takoma Park, Md.</i>			
23a. BURIAL (CREMATION, REMOVAL) (Specify) <i>Burial</i>		23b. DATE THEREOF <i>JAN 20, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ROCK CREEK CEM.</i>		23d. LOCATION (City, town, or county) (State) <i>WASHINGTON D C</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Baker</i> ADDRESS <i>254 Gaffney St NW</i>				25a. REC'D BY REGISTRAR DATE <i>JAN 20 '61</i>		25b. REGISTRAR'S SIGNATURE <i>William S. Kline</i>	

1/17/61 Dr. Queen contacted Dr. Frank J. Broschart, Dep. Med. Examiner,
and Dr. Broschart approved of Dr. Queen signing this certificate.

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

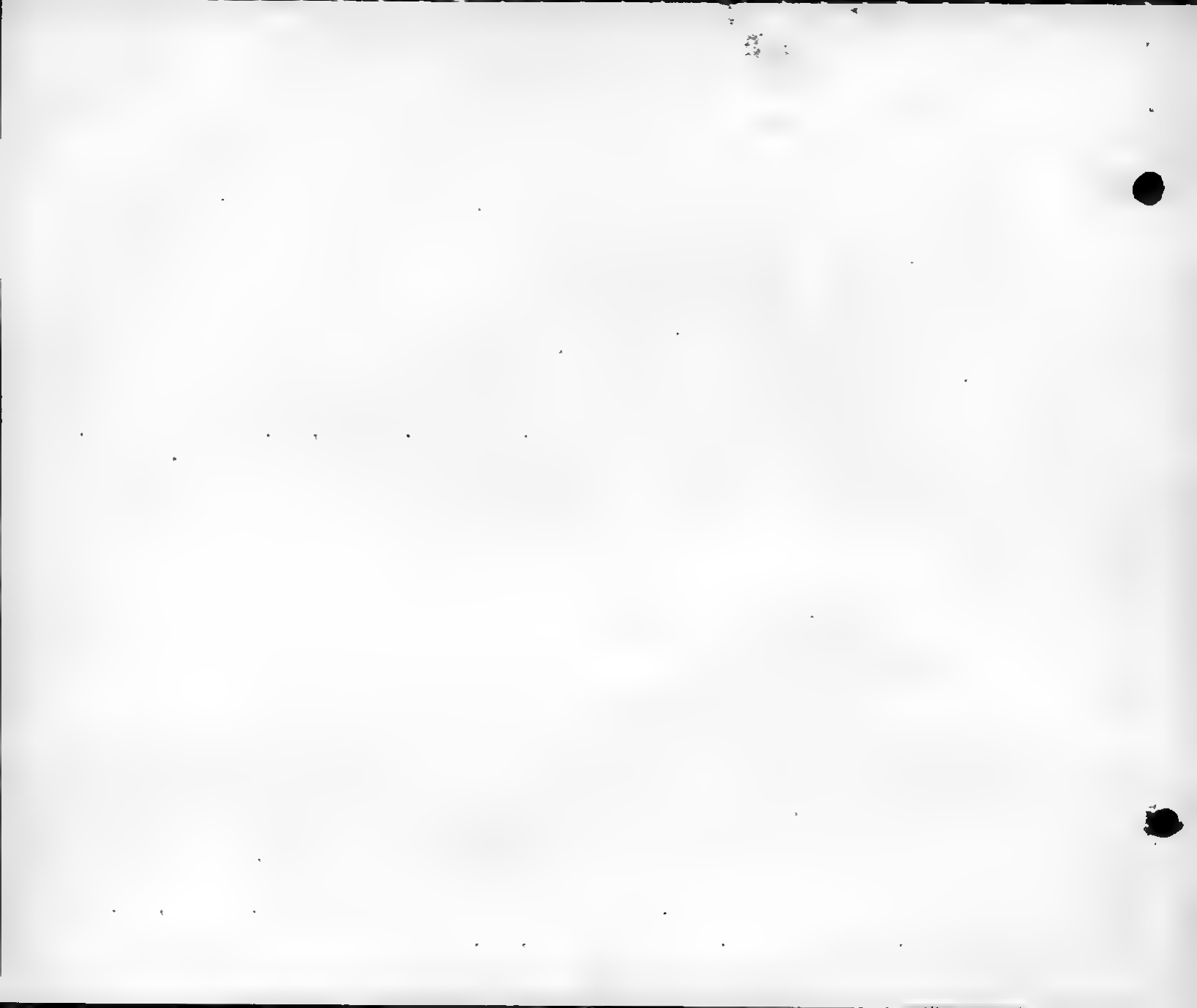
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899

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66892

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7228 Spruce Ave.</u>	
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION <u>Wash. San. & Hosp.</u>		d. STREET ADDRESS <u>Takoma Park, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Louise Weisenthal Miller</u>		4. DATE OF DEATH <u>1-14-1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-90</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary - Retired</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Reconstruction Finance Corp.</u>	
12. BIRTHPLACE (State or foreign country) <u>Connecticut</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>David Miller</u>		15. MOTHER'S MAIDEN NAME <u>Isabelle Robertson</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. SOCIAL SECURITY NO. <u>yes</u>	
18. INFORMANT Address <u>Mr. Robert D. Miller, 12,904 Grenoble Dr. Rockville, Md.</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>one month</u>	
20. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u> DUE TO <u>581.0</u>		21. (b) <u>Cirrhosis of liver</u> DUE TO <u>Unknown</u>	
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
24a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		24b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
25a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		25b. INJURY OCCURRED While at work Not while at work	
26a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26b. (City or town) (County) (State)	
27. I certify that (I) (the hospital) attended the deceased from <u>March 22, 1958</u> to <u>January 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 13, 1961</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
28a. SIGNATURE <u>Arnon H. Traum</u> M.D.		28b. DATE SIGNED <u>Jan 16 1961</u>	
29a. PHYSICIAN'S NAME (Type) <u>ARNON H. TRAUM</u>		29b. ADDRESS <u>9237 Georgia Ave., Silver Spring, Md.</u>	
30a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		30b. DATE THEREOF <u>1/18/61</u>	
30c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		30d. LOCATION (City, town or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
31. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pomeroy, Inc.</u>		32. ADDRESS <u>SILVER SPRING, MD.</u>	
33a. REC'D BY REGISTRAR <u>JAN 25 '61</u>		33b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



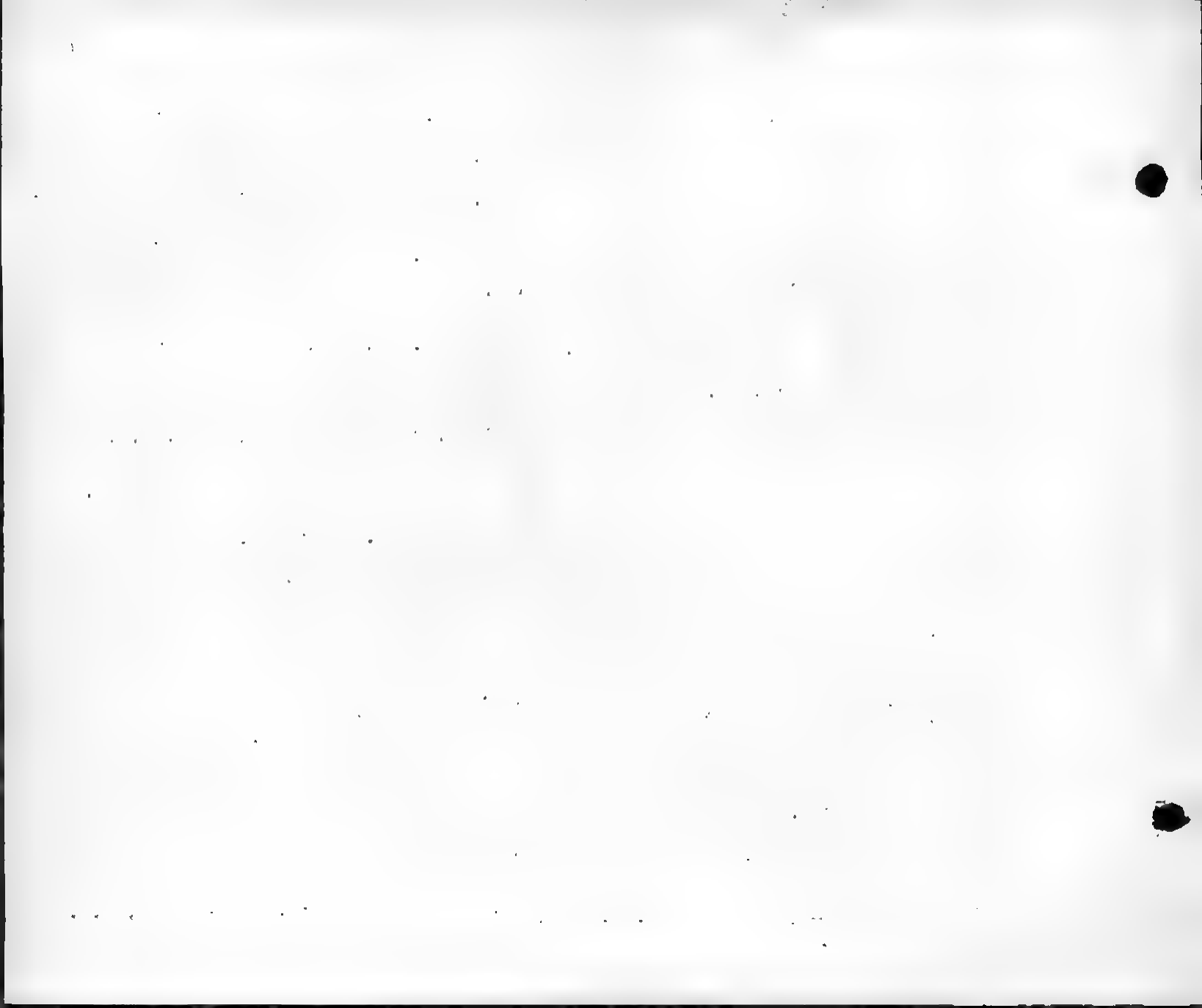
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Form 9 Filed 12-16-61 et
CERTIFICATE OF DEATH

Reg. Dist. No.

00893

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Oak,		c. LENGTH OF STAY IN TB ten years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		d. STREET ADDRESS Rt. 2 Stewart Lane, White Oak	
3. NAME OF DECEASED (Type or print) First Harry Middle Stacey Last Moody Jr.		4. DATE OF DEATH Month January Day 28 Year 61 19	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1912
9. AGE (In years last birthday) 48 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sanitary Com.	
11. BIRTHPLACE (State or foreign country) King Wm. Co., Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Stacey Moody, Sr.		14. MOTHER'S MAIDEN NAME Frances Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Cyril B. Moody Address 2913 7th St. N.E. DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage or Tumor DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unequal Pupils, Weak Left side, Projectile emesis DUE TO (c) Renal Insufficiency; Reaction to MS 1/2.			INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Asthma; Obesity; Renal insufficiency			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) X-75	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 16, 1958 to January 28, 61 , that I last saw the deceased alive on January 27, 1961 , and that death occurred at 1:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck, Rt. 1 Silver Spring DATE SIGNED 1/28/61			
ACTUAL SIGNATURE Webster Sewell M.D.		PHYSICIAN'S NAME (Type) Webster Sewell	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-31-61	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Suitland Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN T. KINCE & Co		24a. REC'D BY REGISTRAR FEB 1 '61	
24b. REGISTRAR'S SIGNATURE C. L. S. K. K.			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

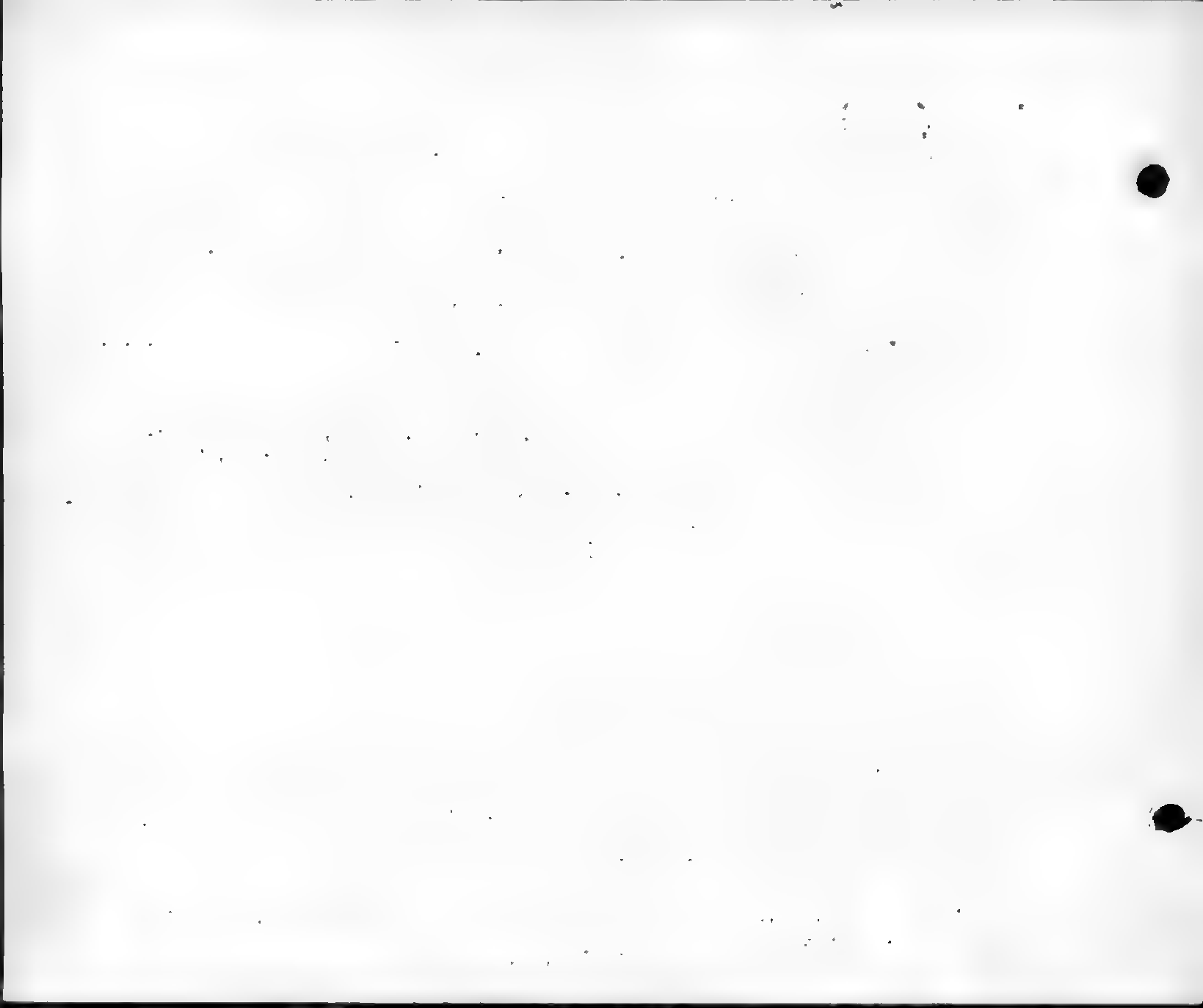
901

CERTIFICATE OF DEATH

Reg. Dist. No.

10894

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm ss on) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 17			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 900 DOMER AVENUE				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			
f. STREET ADDRESS 900 DOMER AVENUE				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CATHERINE Middle L. Last MOON				4. DATE OF DEATH Month JAN. Day 14 Year 19 61			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 16, 1878		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 8 Days 14 Hours 14 Min.	IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOMEMAKER retired		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) CASTEL, GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CONRAD SCHULTZ				14. MOTHER'S MAIDEN NAME MARTHA WACHTMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT Mrs. Donald F. Poole, 900 Domer Ave. Takoma Park, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis (Heart Disease) 446X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) Chronic Nephritis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 34.000			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) BALTIMORE				(County)		(State)	
21. I certify that I attended the deceased from 3/7/52 , 19 to 5/14/61 , 19, that I last saw the deceased alive on 1/14/61 , 19, and that death occurred at 12:50 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. O'Keefe				ADDRESS (Street, city or town, state) 4501 Conn Ave NW Wash D.C.			
PHYSICIAN'S NAME (Type) James G. O'Keefe				DATE SIGNED 5/14/61			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 17, 1961		22c. NAME OF CEMETERY OR CREMATORY LOUDOUN PARK CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JAN 17 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. House							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

<div> <div>12</div> <div>66895</div> </div> <div> <div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div> </div> <div> <div>5</div> <div>6</div> </div> <div> <div>7</div> <div>8</div> </div> <div> <div>9</div> <div>10</div> </div> <div> <div>11</div> <div>12</div> </div> <div> <div>13</div> <div>14</div> </div> <div> <div>15</div> <div>16</div> </div> <div> <div>17</div> <div>18</div> </div> <div> <div>19</div> <div>20</div> </div> <div> <div>21</div> <div>22</div> </div> <div> <div>23</div> <div>24</div> </div> <div> <div>25</div> <div>26</div> </div> <div> <div>27</div> <div>28</div> </div> <div> <div>29</div> <div>30</div> </div> <div> <div>31</div> <div>32</div> </div> <div> <div>33</div> <div>34</div> </div> <div> <div>35</div> <div>36</div> </div> <div> <div>37</div> <div>38</div> </div> <div> <div>39</div> <div>40</div> </div> <div> <div>41</div> <div>42</div> </div> <div> <div>43</div> <div>44</div> </div> <div> <div>45</div> <div>46</div> </div> <div> <div>47</div> <div>48</div> </div> <div> <div>49</div> <div>50</div> </div> <div> <div>51</div> <div>52</div> </div> <div> <div>53</div> <div>54</div> </div> <div> <div>55</div> <div>56</div> </div> <div> <div>57</div> <div>58</div> </div> <div> <div>59</div> <div>60</div> </div> <div> <div>61</div> <div>62</div> </div> <div> <div>63</div> <div>64</div> </div> <div> <div>65</div> <div>66</div> </div> <div> <div>67</div> <div>68</div> </div> <div> <div>69</div> <div>70</div> </div> <div> <div>71</div> <div>72</div> </div> <div> <div>73</div> <div>74</div> </div> <div> <div>75</div> <div>76</div> </div> <div> <div>77</div> <div>78</div> </div> <div> <div>79</div> <div>80</div> </div> <div> <div>81</div> <div>82</div> </div> <div> <div>83</div> <div>84</div> </div> <div> <div>85</div> <div>86</div> </div> <div> <div>87</div> <div>88</div> </div> <div> <div>89</div> <div>90</div> </div> <div> <div>91</div> <div>92</div> </div> <div> <div>93</div> <div>94</div> </div> <div> <div>95</div> <div>96</div> </div> <div> <div>97</div> <div>98</div> </div> <div> <div>99</div> <div>100</div> </div>											
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

903

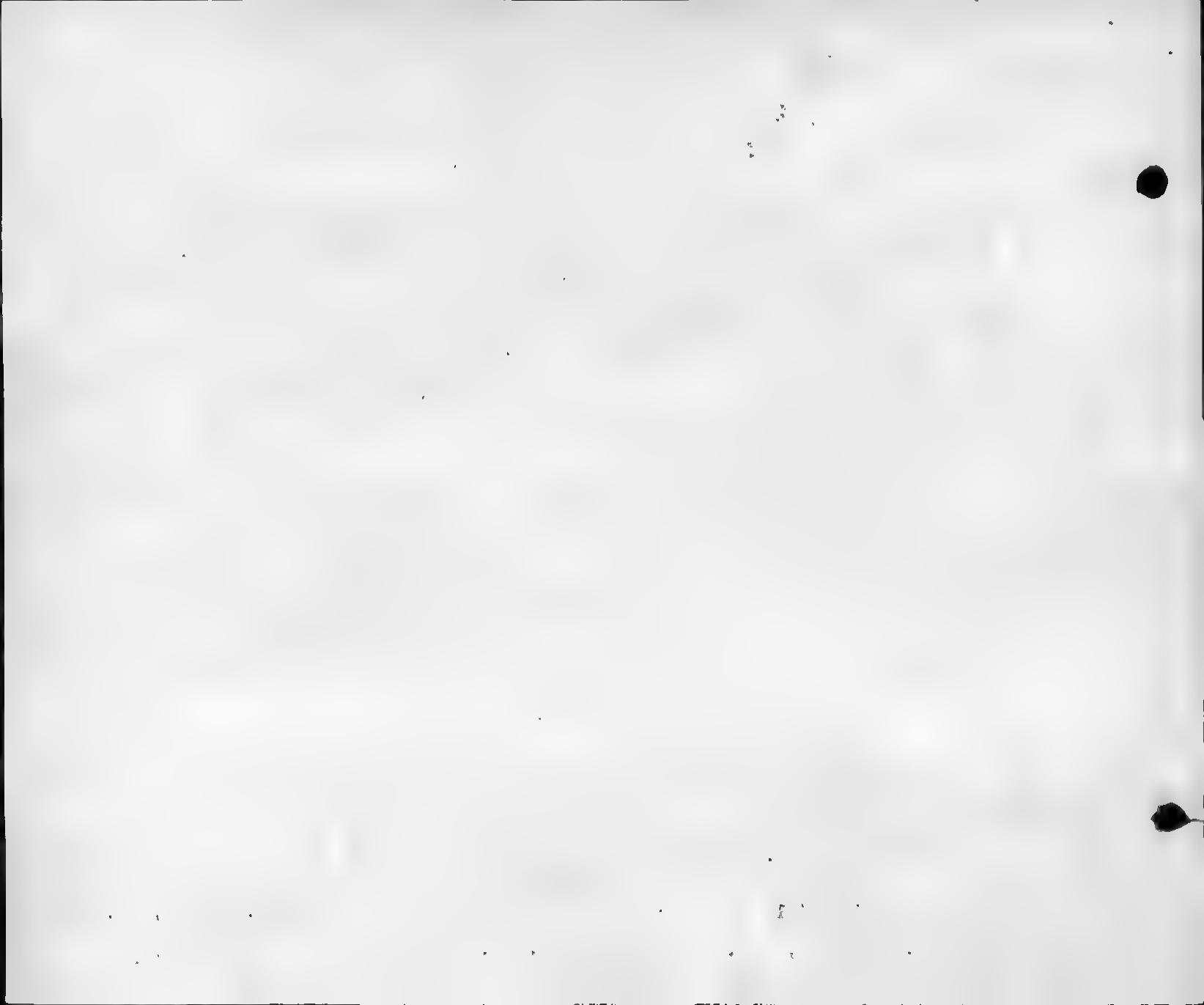
CERTIFICATE OF DEATH

61896

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if not within residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9128 Walden Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>EDNA BROWNING MOORE</u>		4. DATE OF DEATH Last <u>1</u> Month <u>1</u> Day <u>1</u> Year <u>1961</u>									
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-76</u>								
9. AGE (In years last birthday) <u>84</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DANIEL WOOTEN</u>									
14. MOTHER'S MAIDEN NAME <u>unknown Stevenson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Gen. in-law</u> Address <u>Sauce</u>									
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> (b) <u>Hypertension</u> (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)								
21. I certify that () (this hospital) attended the deceased from <u>July</u> 19 <u>59</u> to <u>Jan</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Dec 31</u> 19 <u>60</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>1/1/61</u>									
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>212 University Blvd E. CS Med</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE OF DEATH <u>1/3/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>	23d. LOCATION (City, town or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>								
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 6 '61</u>									
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

904

00897

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>53 days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19 Takoma Park</u>					
				f. STREET ADDRESS <u>8102 Greenwood Ave.</u>					
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Jessie</u> First <u>Glessner</u> Middle <u>Moore</u> Last				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 1, 1875</u>			
9. AGE (in years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u>		IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>					
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>William Glessner</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Daddysman</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO <u>-</u>					
17. INFORMANT <u>Hospital Records</u>				Address <u>-</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>170X Carcinomatosis of Lung, Bones, & Carcinoma of R Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> (c) <u>-</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>								INTERVAL BETWEEN ONSET AND DEATH <u>30 Yrs ago</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month <u>12</u> Day <u>11</u> Year <u>1961</u> Hour <u>10</u> o. m. <u>0</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>500 Underwood St. NW Wash. D.C.</u>				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> 19 <u>61</u> to <u>1/24</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> 19 <u>61</u> , and that death occurred at <u>10</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Chas H. Wolohon</u> M.D.				22b. DATE SIGNED <u>1/24</u>					
22c. PHYSICIAN'S NAME (Type) <u>Chas H. Wolohon</u>				22d. ADDRESS <u>500 Underwood St. NW Wash. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JAN 26 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM</u>		23d. LOCATION (City or town or county) (State) <u>PRINCE GEORGE CO MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Carroll</u> ADDRESS <u>254 Carroll St. NW</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 26 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>John A. Carroll</u>									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00898

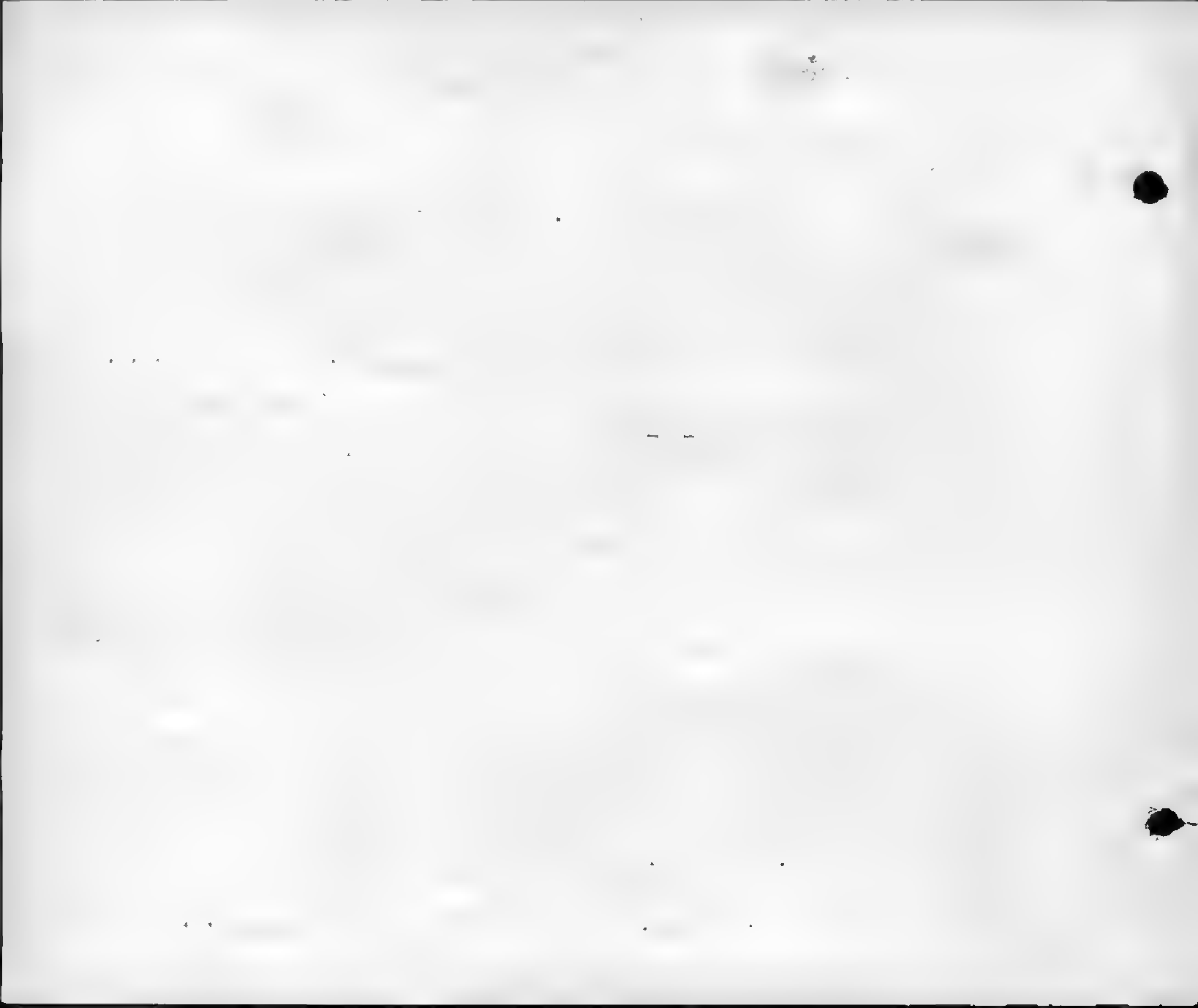
905

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 3713 Kennedy Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Vincent Last Morris				4. DATE OF DEATH Month January Day 2 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 8, 1907	
9. AGE (In years last b. rthday) 53 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foreman		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Morris				14. MOTHER'S MAIDEN NAME (Unknown) Tyler (Sarah Mandanyohl)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-05-2118		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 162.1 Congestive Heart Failure DUE TO (b) Chronic Respiratory Insufficiency DUE TO (c) Carcinomatous (Bronchogenic) Myelopathy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 6, 19 60 , to January 2, 19 61 , that I last saw the deceased alive on January 2, 19 61 , and that death occurred at 6:10A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/2/61 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Forbes H. Norris M.D. PHYSICIAN'S NAME (Type) Forbes H. Norris, M.D.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF January 4, 1961		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Funeral Dir.				24a. REC'D BY REGISTRAR DATE JAN 5 '61		24b. REGISTRAR'S SIGNATURE Charles S. Howard	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



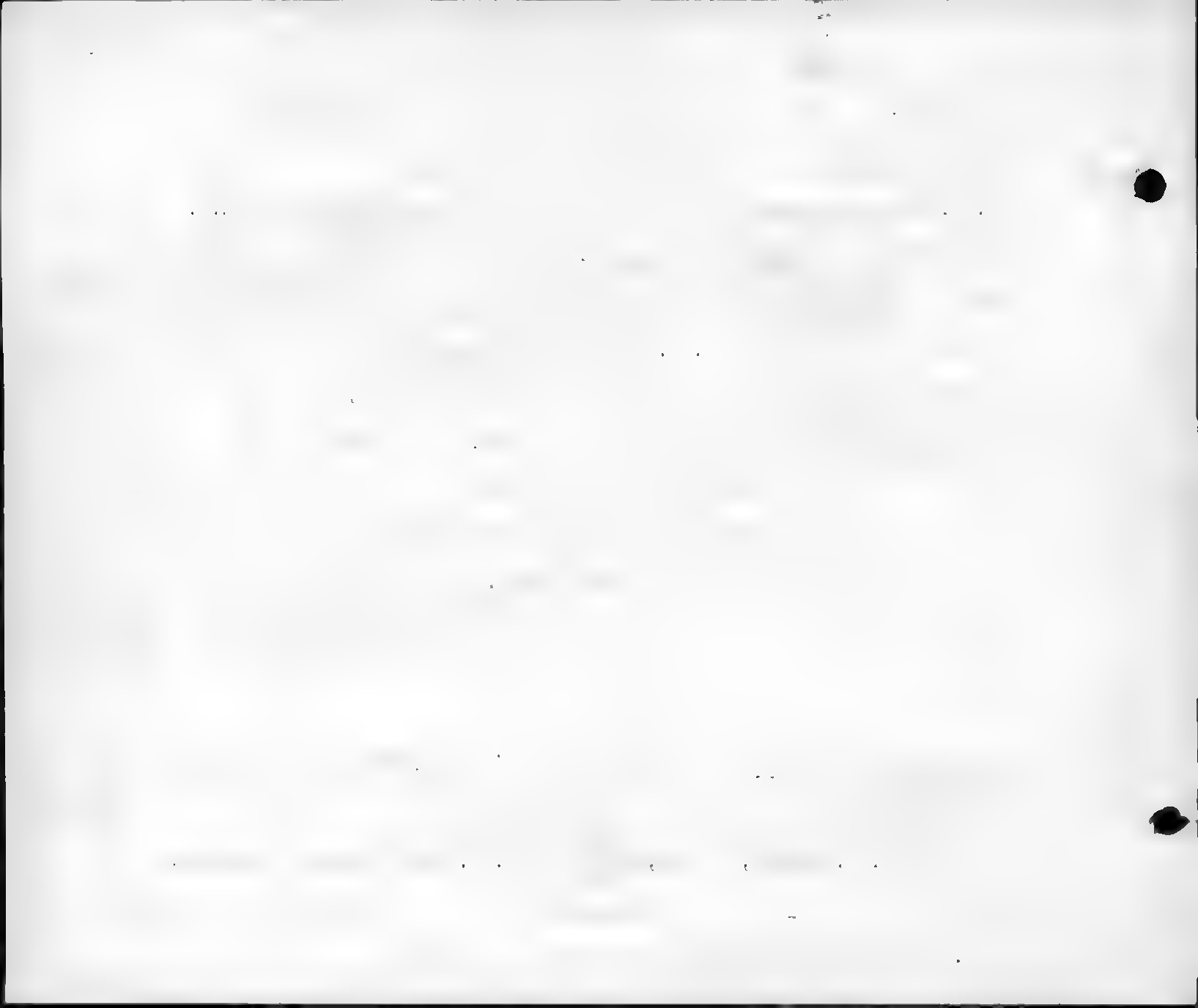
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10899

906

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 35 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4000 Massachusetts Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John Broder MOSS				4. DATE OF DEATH Month Day Year January 31 1961			
5 SEX Male		6 COLOR OR RACE Caucasian		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years, lost birthday) yrs 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11 BIRTHPLACE (State or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Andrew MOSS				14. MOTHER'S MAIDEN NAME Carolyn KOBBELEOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1923 to 1953 056-30-7225		17 INFORMANT Address (W) Mrs. Dorothy Moss, same as #2 above			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular Collapse 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Increased intracranial pressure DUE TO (c) Malignant brain tumor. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 27 5:40 PM to Jan. 31 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 31 1961 , and that death occurred at M. from the causes and on the date stated above							
22a. SIGNATURE J. H. Miller				22b. DATE SIGNED 2-1-61			
22c. PHYSICIAN'S NAME (Type) J. H. MILLER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR FEB 3 '61		25b. REGISTRAR'S SIGNATURE Carlton S. Knead	



10 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD 907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB unknown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 6 Sedgewick Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gerald W. Movius		4. DATE OF DEATH 1 25 19 61		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7/27/07	
9. AGE (In years last birthday) 53 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Writer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Movius	
14. MOTHER'S MAIDEN NAME Anna Murry		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 501-01-5706	
17. INFORMANT Eleanor, wife		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Subdural hematoma, left DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH hours 1 week	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Slipped on ice & fell to street					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped on ice & fell to street		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year 5 1-19 1961		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20e. (City or town) Washington (County) DC	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
SIGNATURE Frank J. Broschert		M.D. FRANK J. Broschert		DATE SIGNED 1-25-61	
EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/61	
23. FUNERAL DIRECTOR The S.H. Hines Co. Washington, D. C.		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or country) (State) Washington, D. C.	
24a. REC'D BY REGISTRAR DATE FEB 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

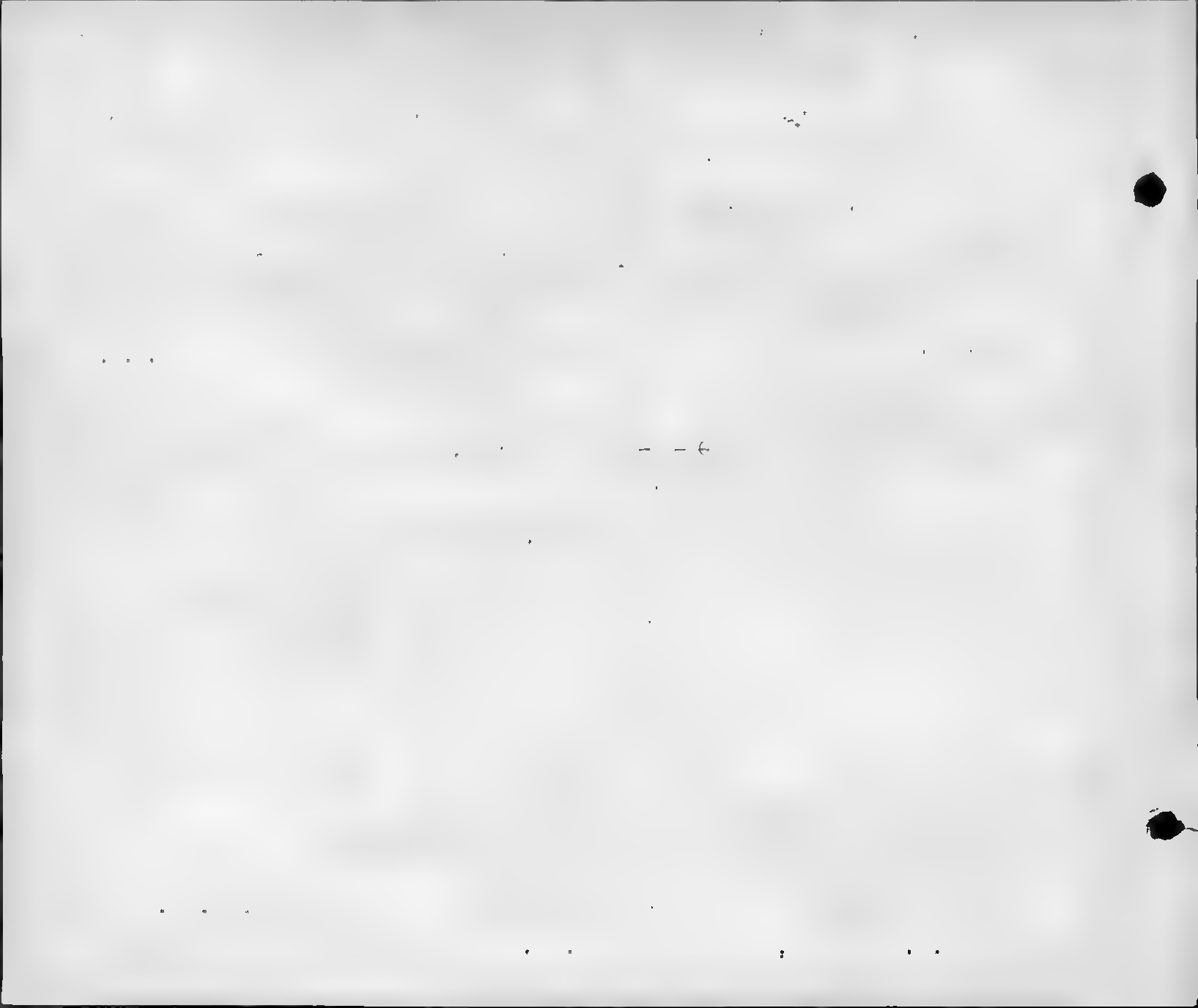
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CERTIFICATE OF DEATH

Reg. Dist No.

66901

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		2. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bemulah Middle Ann Last Munger		4. DATE OF DEATH Month January Day December Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12-1881
9. AGE (In years lost birthday) 79		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper---Own home		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John B. Munger		14. MOTHER'S MAIDEN NAME Eliza Huffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. INFORMANT Address Fred Campbell, Poolesville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Bronchial, 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Asteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 6 days 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4 January, 1961 , to 8 January, 1961 , that I last saw the deceased alive on 2 January, 1961 , and that death occurred at 2 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) Barnesville DATE SIGNED 8 Jan 61	
PHYSICIAN'S NAME (Type) Gordon M. Smith		Barnesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 12/10/61	22c. NAME OF CEMETERY OR CREMATORY Monocacy	22d. LOCATION (City, town, or county) (State) Beallsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR Barnesville DATE JAN 11 '61	
		24b. REGISTRAR'S SIGNATURE Clara S. Kneass	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 66962

909

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase 42			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING Home				d. STREET ADDRESS 4504 Walsh St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Louise Middle R Last Niess				4. DATE OF DEATH Jan 14, 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUN 26 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON DC	
12. CITIZEN OF WHAT COUNTRY? U S							
13. FATHER'S NAME JAMES RICHARDSON				14. MOTHER'S MAIDEN NAME LUBERTA DEENER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address Hospital Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic heart failure INTERVAL BETWEEN ONSET AND DEATH 1 mo.							
DUE TO (b) Hypertensive heart disease years.							
DUE TO (c) Diabetes mellitus 5 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from Feb 1956 to Jan. 12, 1961 , that I last saw the deceased alive on Jan 12, 1961 , and that death occurred at 7:25 PM , from the causes and on the date stated above							
ACTUAL SIGNATURE C.P. Ryland				ADDRESS (Street, city or town, state) 4400-49 St N.W. DATE SIGNED 1-14-61			
PHYSICIAN'S NAME (Type) C.P. RYLAND, M.D.				Washington 16 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/61		22c. NAME OF CEMETERY OR CREMATORY Oakhill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE For + Burcho. Son 3034 9th St				24a. REC'D BY REGISTRAR DATE JAN 18 '61		24b. REGISTRAR'S SIGNATURE Lin 1st 8 Trans	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

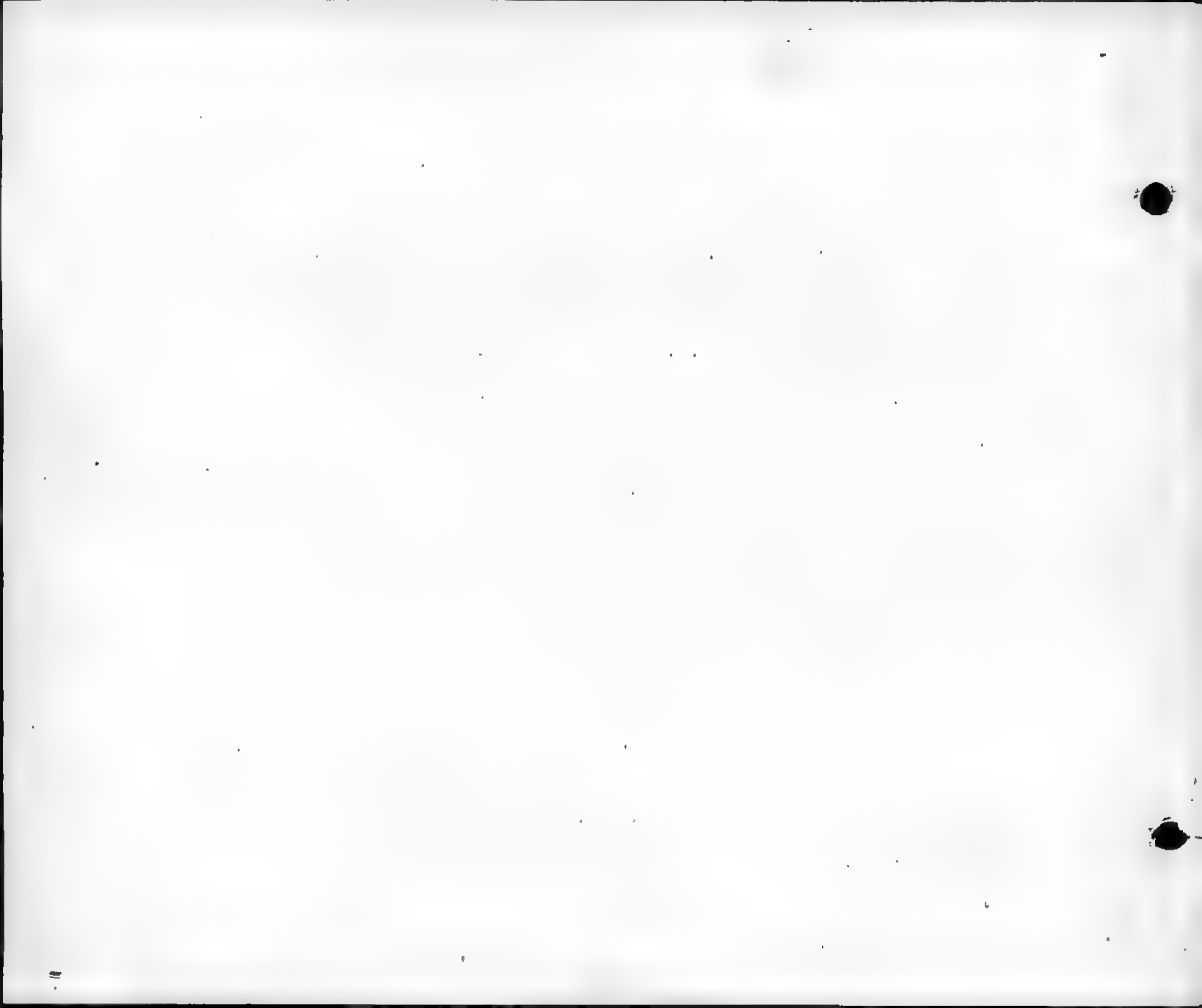
CERTIFICATE OF DEATH

Reg. Dist. No. **00903**

910

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN Ib d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 543 W. Montgomery Avenue		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 543 W. Montgomery Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT HARRY OAKES First Middle Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4/21/1895 9. AGE (In years last birthday) 65 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. 11. BIRTHPLACE (State or foreign country) Mass. 12. CITIZEN OF WHAT COUNTRY? US		4. DATE OF DEATH January 20, 1961 Month Day Year 13. FATHER'S NAME Robert H. Oakes 14. MOTHER'S MAIDEN NAME Mary Hunter 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW 1 16. SOCIAL SECURITY NO. None INFORMANT Juanita H. Oakes Address Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction (b) Hypertensive heart disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 min 20 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 1958 to Jan 20, 1961 , that I last saw the deceased alive on Jan 20, 1961 , and that death occurred at 245 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. G. Hall M.D. 615 W. Montgomery Ave. Rockville, Md. 1/20/61 PHYSICIAN'S NAME (Type) W. G. Hall - 615 W. Montg. Ave., Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/24/61 22c. NAME OF CEMETERY OR CREMATORY Arlington National 22d. LOCATION (City, town, or county) (State) Arlington, Virginia		23. FUNERAL DIRECTOR'S SIGNATURE Lyson Wheeler Funeral Home ADDRESS 1331 E. Montgomery Avenue, Rockville, Maryland 24a. REC'D BY REGISTRAR DATE JAN 25 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



911

CERTIFICATE OF DEATH

Reg. Dist. No.

66904

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(NONE) 719 Woodburn Rd.</u>		d. STREET ADDRESS <u>719 Woodburn Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Winand</u> Last <u>O'BRIEN</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 19, 1862</u>
9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR: IF UNDER 74 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Winand</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Gault</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>-----</u>	
17. INFORMANT <u>Mary Kirkley</u>		Address <u>719 Woodburn</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January, 1960</u> to <u>Dec 31, 1960</u> , that I last saw the deceased alive on <u>Dec 31, 1960</u> , and that death occurred at <u>4A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Viers Hill Rd. Rockville, Md.</u> DATE SIGNED <u>Herman P. Chapauzini</u>			
ACTUAL SIGNATURE <u>Herman P. Chapauzini</u> M.D.		PHYSICIAN'S NAME (Type) <u>Herman P. Chapauzini</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holt Rood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>son Wheeler-1331 E Montg. Ave.</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de- necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. **FUNERAL DIRECTOR:** Page 3 should be used a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

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FOR STATE
HEALTH DEPT.

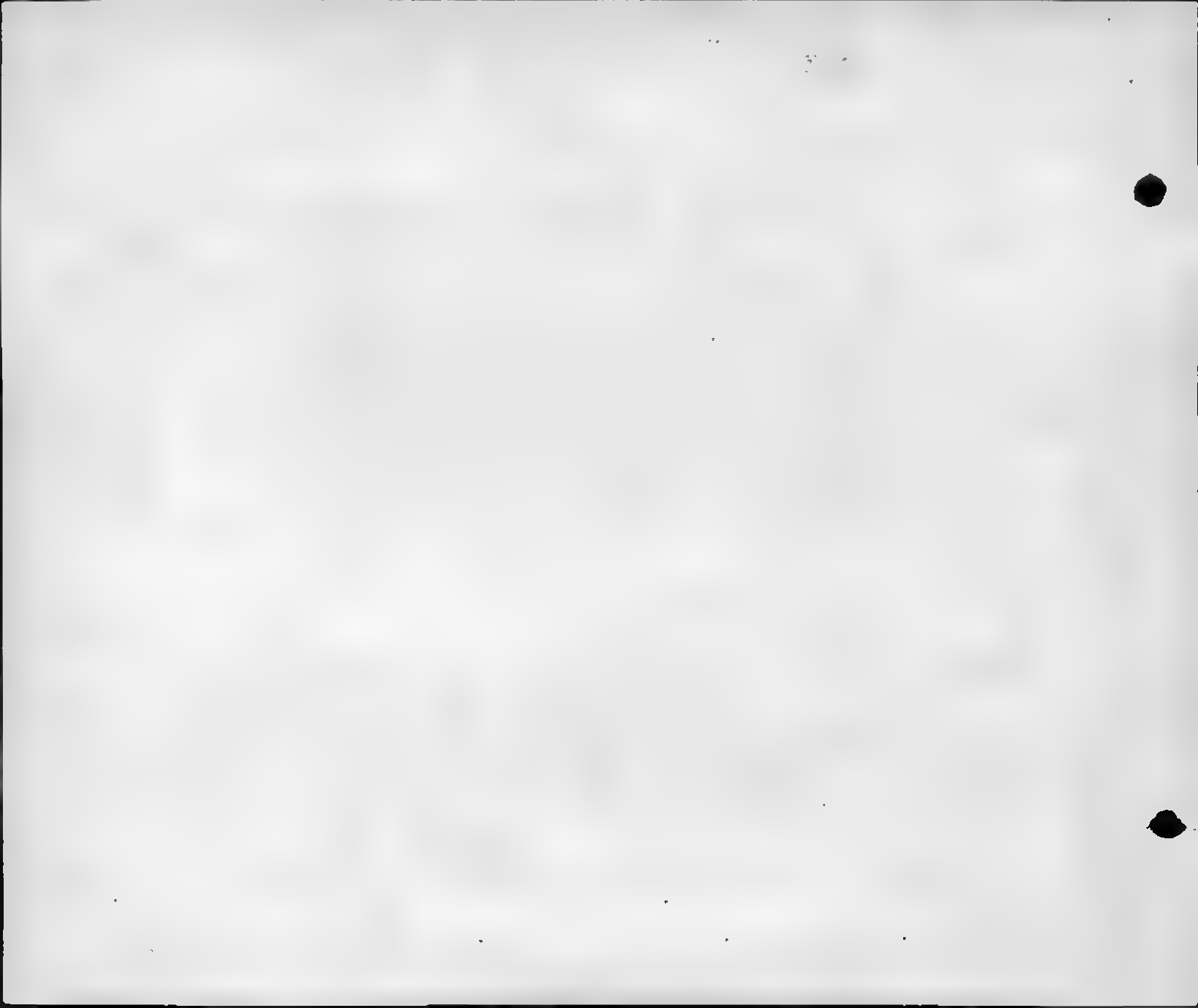
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00905

1. PLACE OF DEATH COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>P. 4.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>3311 Standard Street</u>	
3. NAME OF DECEASED (Type or print) <u>George Timothy O'Neill</u>		4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. DATE OF BIRTH Month <u>May</u> Day <u>28</u> Year <u>1904</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (in years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		9b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10. FATHER'S NAME <u>George O'Neill</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u>		13. SOCIAL SECURITY NO. <u>NONE</u>	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>420</u> (a), stating the underlying cause last. (c) <u>1</u> DUE TO <u>1</u> DUE TO <u>1</u> DUE TO <u>1</u>		15. INFORMANT <u>Mrs. Laura B. O'Neill</u> Address <u>3311 Standard St. Hyattsville, Md.</u>	
16. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)		17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1961</u> Hour a.m. <u>19</u> p.m. <u>19</u>		19b. INJURY OCCURRED 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20b. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
22a. <u>BURIAL</u>		22b. <u>2/2/61</u>	
22c. <u>GEO. WASH. CEMETERY</u>		22d. <u>PRINCE GEORGE COUNTY, MD.</u>	
23. SIGNATURE OF MEDICAL EXAMINER <u>Frank J. Broschaw</u>		24. REC'D BY REGISTRAR DATE <u>FEB 6 '61</u>	
25. SIGNATURE OF REGISTRAR <u>Raymond A. Zioka</u>		26. REGISTRAR'S SIGNATURE <u>Caroline S. Kneass</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

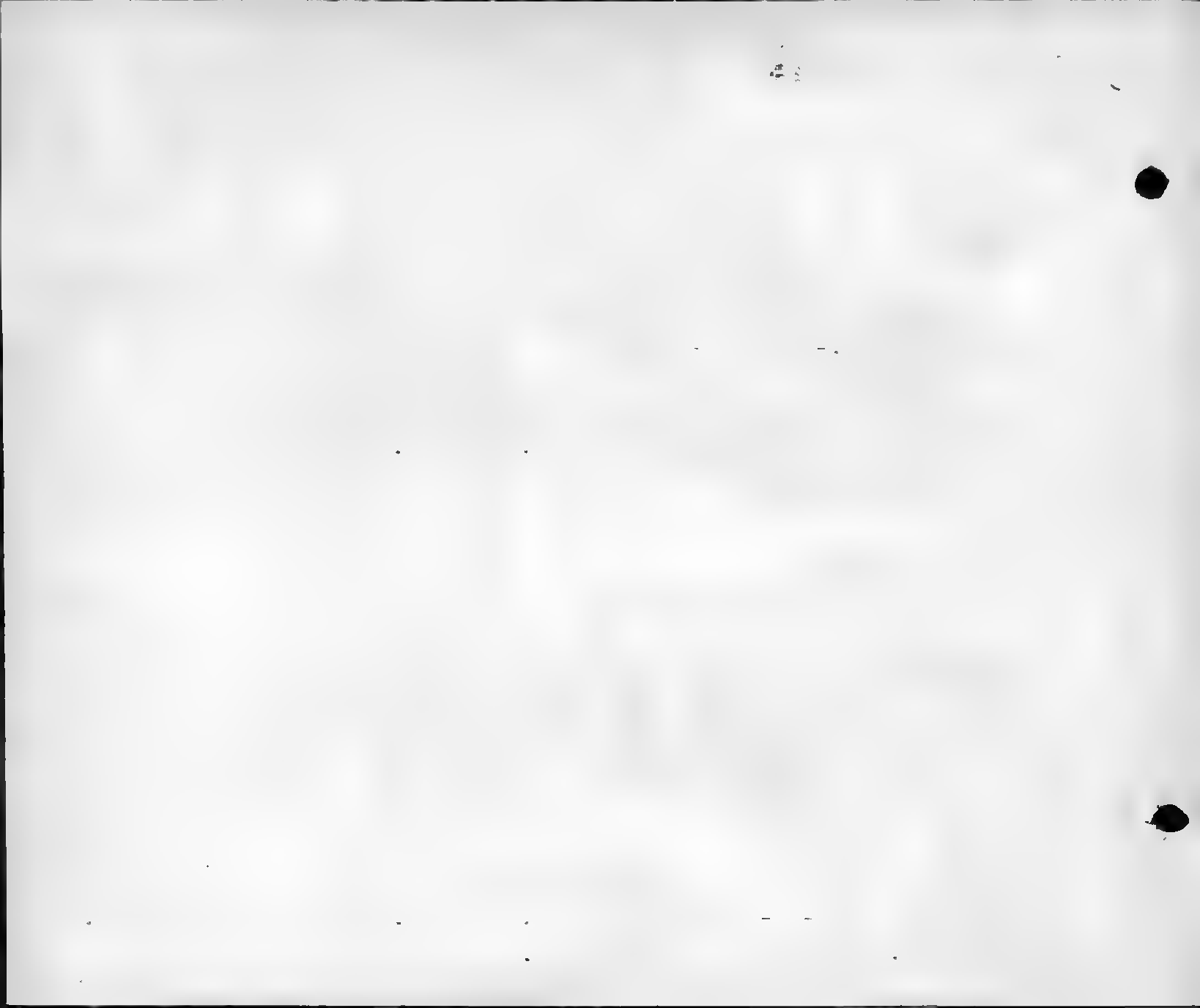
16906

913

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>1 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Longview</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4105 Stanford St</u>				d. STREET ADDRESS <u>1620 Westside Highway</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>Peairs</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-16-1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business Prop.-Retired - Laundry</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David Allen Peairs</u>				14. MOTHER'S MAIDEN NAME <u>Esther Drennan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Daughter</u> <u>Mrs. Ronald C. Kinsey</u>		Address <u>Same as Item #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause last. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>				22b. DATE THEREOF <u>1-12-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Longview Mem. Park Cem.</u>	
				22d. LOCATION (City, town, or county) <u>Cowlitz County, Wash.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 13 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY N. J. ALI EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



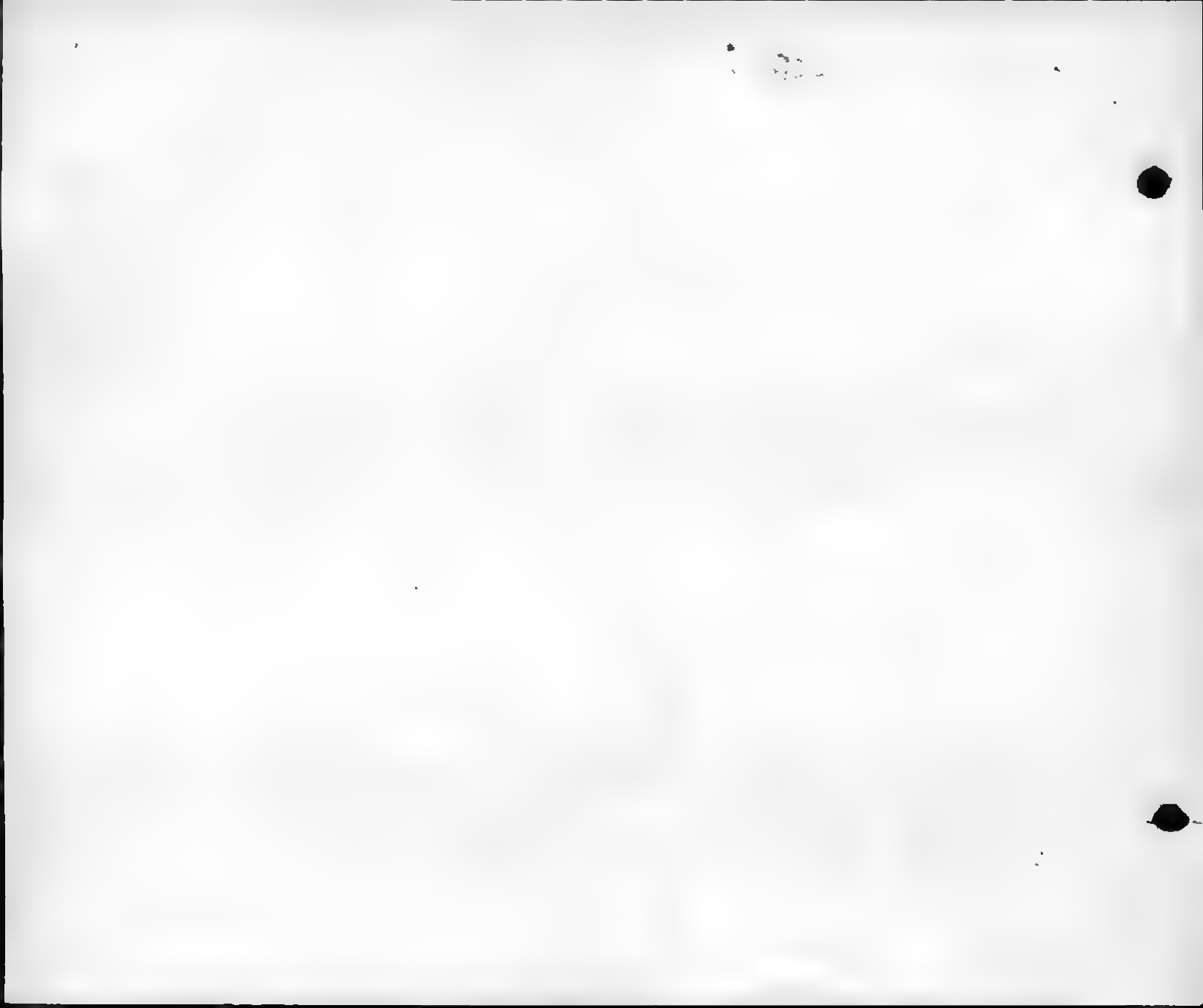
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

914

00907

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Chevy Chase</u>			
c. LENGTH OF STAY IN 1b <u>25 days</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>14222 Oak Ridge Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leighton H.</u> Middle <u>Peebles</u> Last <u></u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/83</u>	9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS: Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>William Peebles</u>				14. MOTHER'S MAIDEN NAME <u>Annie L. Bradbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-38-4790</u>		17. INFORMANT <u>Emilie Peebles-daughter</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia, right, severe, multiple attacks</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost (b) <u>Arteriosclerosis, generalised</u> DUE TO <u>10 yrs +</u> (c) <u>Essential Hypertension, severe</u> DUE TO <u>10 yrs +</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis, bilateral</u>							INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1951</u> to <u>Jan 28</u> , 1961, that (I) (we) last saw the deceased alive on <u>Jan 27</u> , 1961, and that death occurred at <u>3:24</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>1-28-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				22d. ADDRESS <u>4740 Chevy Chase Dr Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>FEB 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Carroll S. Kenna</u>	



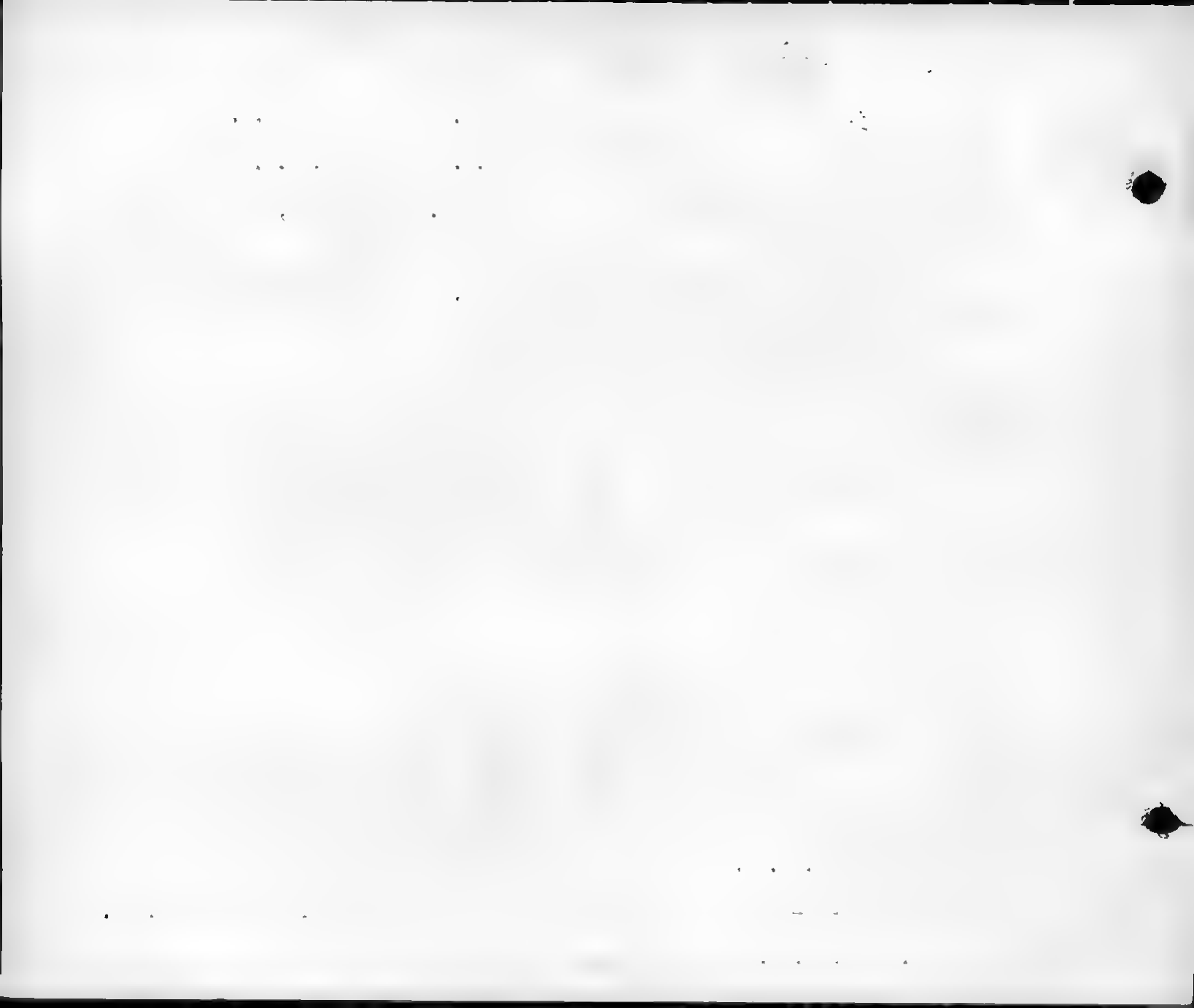
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

315

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

669 8

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N.W. Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>8229 E. Beach Drive,</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Perlis</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 15 1961</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13, 1961</u>
9 AGE (In years last birthday) yrs <u>2</u>		FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>2 10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marvin Elliott Perlis</u>		14. MOTHER'S MAIDEN NAME <u>Edith (Nina) Plotnick</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>father</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS OF NEWBORN</u> DUE TO <u>PREMATURITY</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>JAN 13 1961</u> to <u>JAN 15 1961</u> , that (I) (we) last saw the deceased alive on <u>JAN 14 1961</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stanley Gould</u>		22b. DATE SIGNED <u>JAN 15, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stanley Gould, M. D.</u>		22d. ADDRESS <u>3841 PETERS HILL ROAD, NE, WASH DC 20015</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b DATE THEREOF <u>1-15-61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital, Takoma Park, Md.</u>		23d LOCATION (City, town, or county) (State)	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D.</u>		25a REC'D BY REGISTRAR <u>JAN 17 '61</u>	
ADDRESS <u>Washington San& Hospital</u>		25b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND Item 1 File G211 2-1-61 et

916

CERTIFICATE OF DEATH

00969

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4th BETHESDA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home - 4502 Avamere St.</u>				d. STREET ADDRESS <u>4502 AVAMERE ST</u>			
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>S</u> Last <u>PERRY</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 4 1870</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Kendrick Herndon</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Mrs. William Wine 4502 Avamere St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Heart Dis</u> <u>443X</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Apr 11, 1961</u> to <u>1/30, 1961</u> , that I last saw the deceased alive on <u>Jan 27, 1961</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bethesda, Md</u> DATE SIGNED <u>1/30/61</u> ACTUAL SIGNATURE <u>A. J. Brennan</u> M.D. PHYSICIAN'S NAME (Type) <u>A. J. Brennan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-2-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fredericksburg</u>		22d. LOCATION (City, town or county) (State) <u>Fredericksburg, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neaf Funeral Home</u>				ADDRESS <u>4812 Nagawanna</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			



THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

IV

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

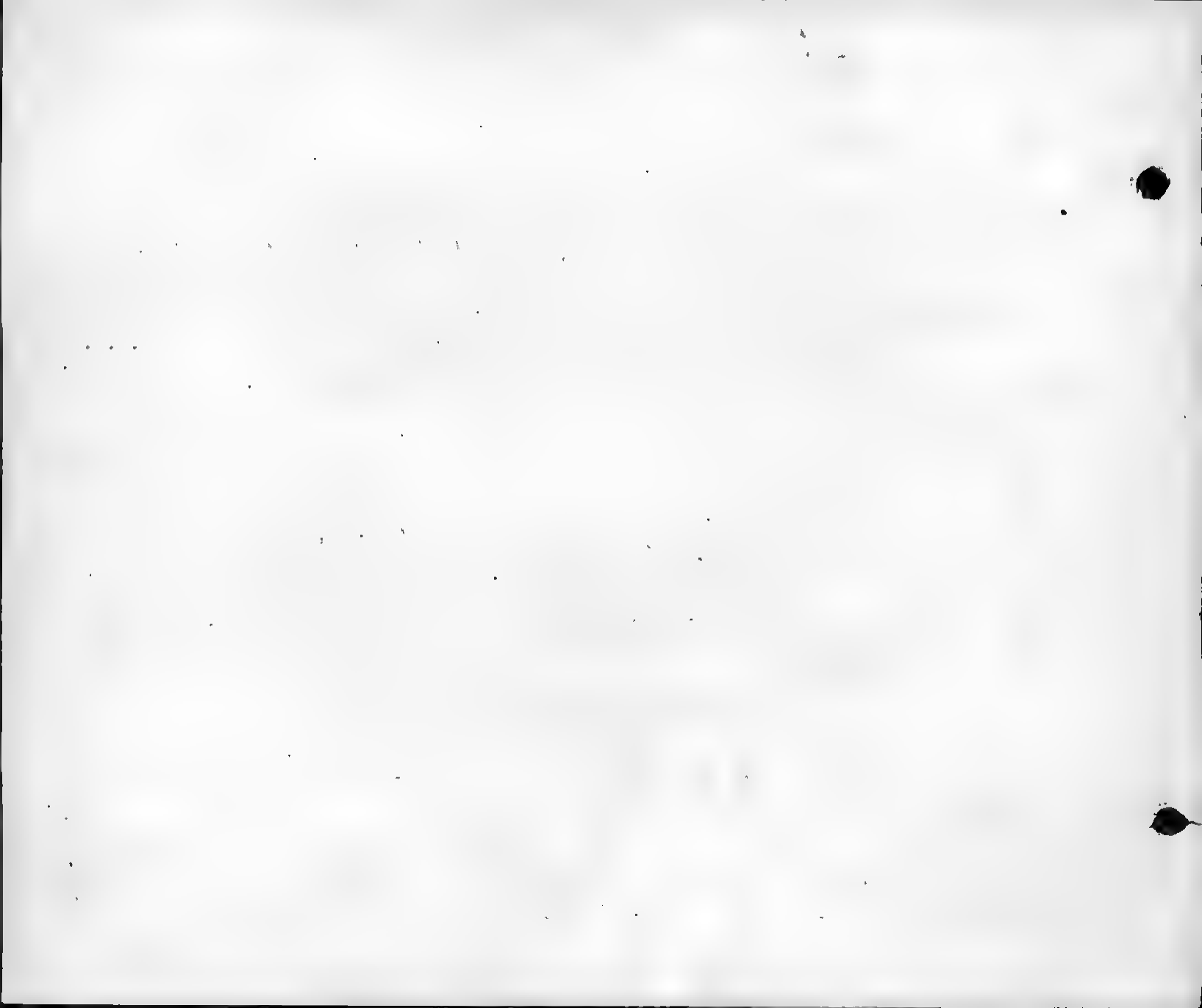
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Item 3 filed 12-14-61 et

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 3003 Weller Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Helen B. Petherbridge				4. DATE OF DEATH Jan 24 1961			
5 SEX Female		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/20/83	
9. AGE (In years last birthday) 77 yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Charlie Burch				14. MOTHER'S MAIDEN NAME Josephine Walter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Husband (Edward)		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 DUE TO Bronchitis pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 50 days 10 years							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 15 1958 to Jan 24 1961 that (I) (we) last saw the deceased alive on Jan 24 1961 and that death occurred at 5:4 M , from the causes and on the date stated above							
22a. SIGNATURE John J. Curry				22b. DATE SIGNED 1/24/61		22c. PHYSICIAN'S NAME (Type) John J. Curry	
22d. ADDRESS 10620 Georgia Ave NE				22e. ADDRESS WASHINGTON DC			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-26-61		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION (City or town, or county) (State) WASHINGTON DC	
24. FUNERAL DIRECTOR'S SIGNATURE J. FRANK JOY				25a. REC'D BY REGISTRAR 5406 ILLINOIS AVE NE		25b. REGISTRAR'S SIGNATURE DATE 1/24/61	

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

918

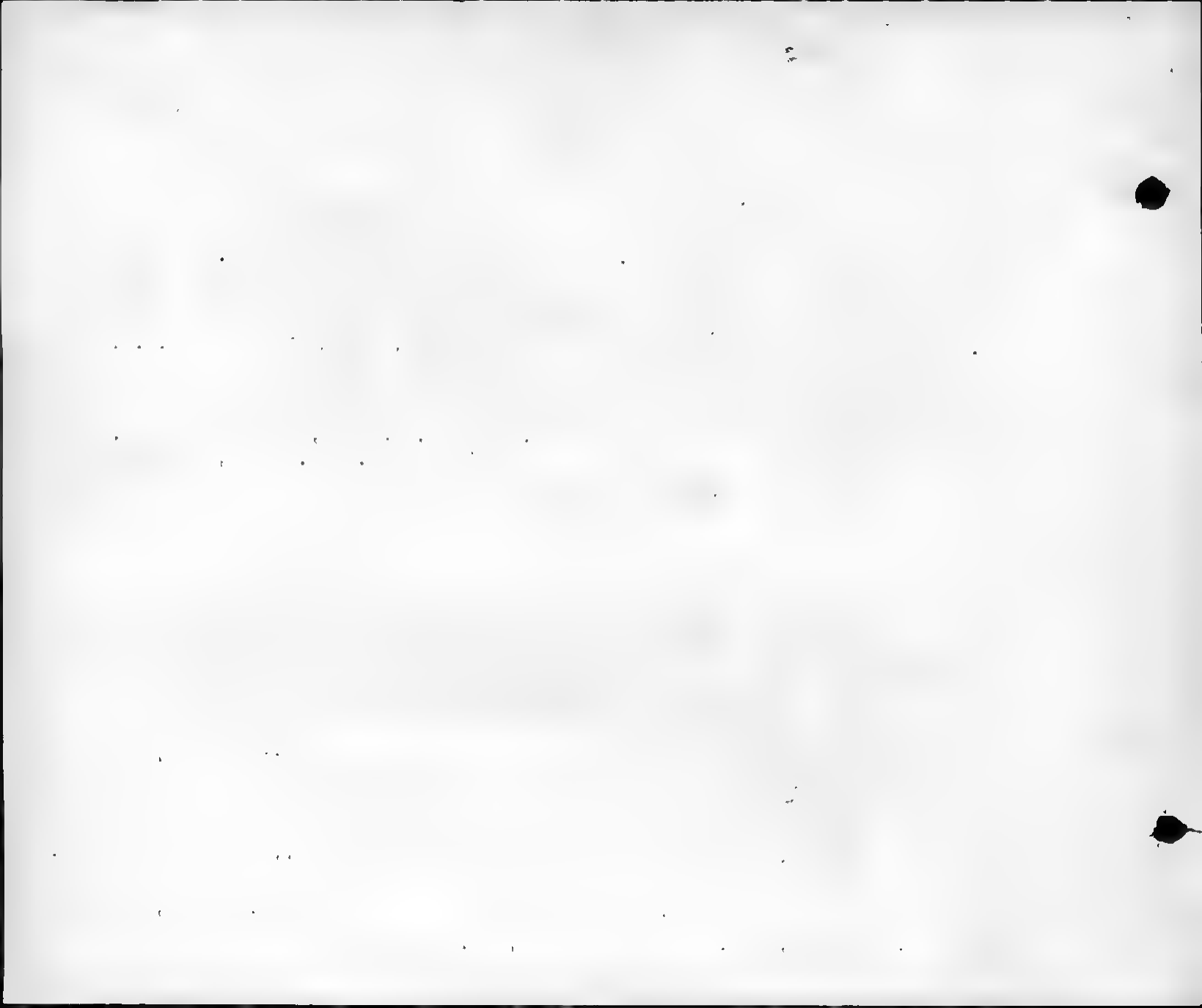
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00911

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 8716 COLESVILLE ROAD			
3. NAME OF DECEASED (Type or print) First MENZIE Middle E. Last PITTMAN				4. DATE OF DEATH Month JAN. Day 9 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/23/82	
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Div. Foreman (retired)				10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving & Printing			
11. BIRTHPLACE (State or foreign country) HANCOCK, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE PITTMAN				14. MOTHER'S MAIDEN NAME VALLORA SHIVES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO NONE		17. INFORMANT Mrs. Elair C. Pittman, 4321 Wright Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchial Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3-4 days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) SILVER SPRING				20g. (County) PRINCE GEORGE		20h. (State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from 1947 to 9 Jan 1961 that (I) (we) last saw the deceased alive on 9 Jan 1961 and that death occurred at 935 PM from the causes and on the date stated above							
22a. SIGNATURE William D. Aud				22b. DATE SIGNED 1/9/61			
22c. PHYSICIAN'S NAME (Type) WILLIAM D. AUD				22d. ADDRESS 9006 Colesville Rd., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/13/61		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE JAN 16 '61	
				25b. REGISTRAR'S SIGNATURE Arthur J. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

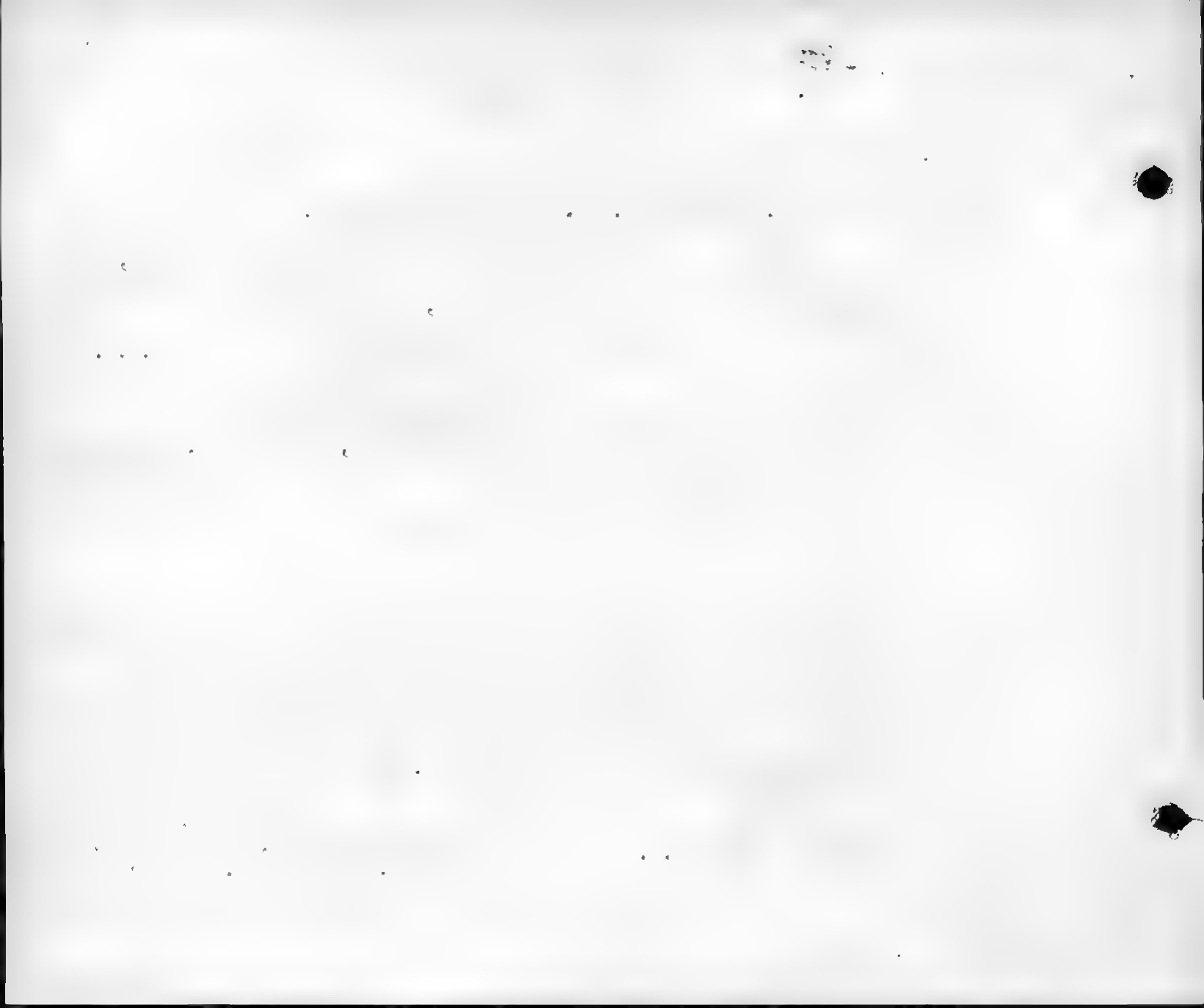
919

CERTIFICATE OF DEATH

60912

Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 79 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Waldwick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldwick d. STREET ADDRESS 58 Waldwick Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Hazel Florence Podgorsky		4. DATE OF DEATH Month Day Year January 28, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1927 November 3, 1928
9. AGE (In years last birthday) 33 yrs		10. FUND 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Morgan		14. MOTHER'S MAIDEN NAME Margaret Morrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Staphylococcal Septicemia DUE TO 726.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Polymyositis Of Unknown Cause DUE TO 3 Years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE TO CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 10, 1960 to January 28, 1961 , that (I) (we) last saw the deceased alive on January 28, 1961 , and that death occurred at 7:20 PM from the causes and on the date stated above.			
22a. SIGNATURE Robert P. Levine M.D.		22b. DATE SIGNED 1/29/61	
22c. PHYSICIAN'S NAME (Type) Robert P. Levine M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 1-29-61		23b. DATE THEREOF 1-29-61	
23c. NAME OF CEMETERY OR CREMATORY Maryrest Cemetery		23d. LOCATION (City, town or county) (State) Darlington, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR Bethesda, Md.	
25b. REGISTRAR'S SIGNATURE Arthur L. Phares		DATE FEB 2 '61	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

920

CERTIFICATE OF DEATH

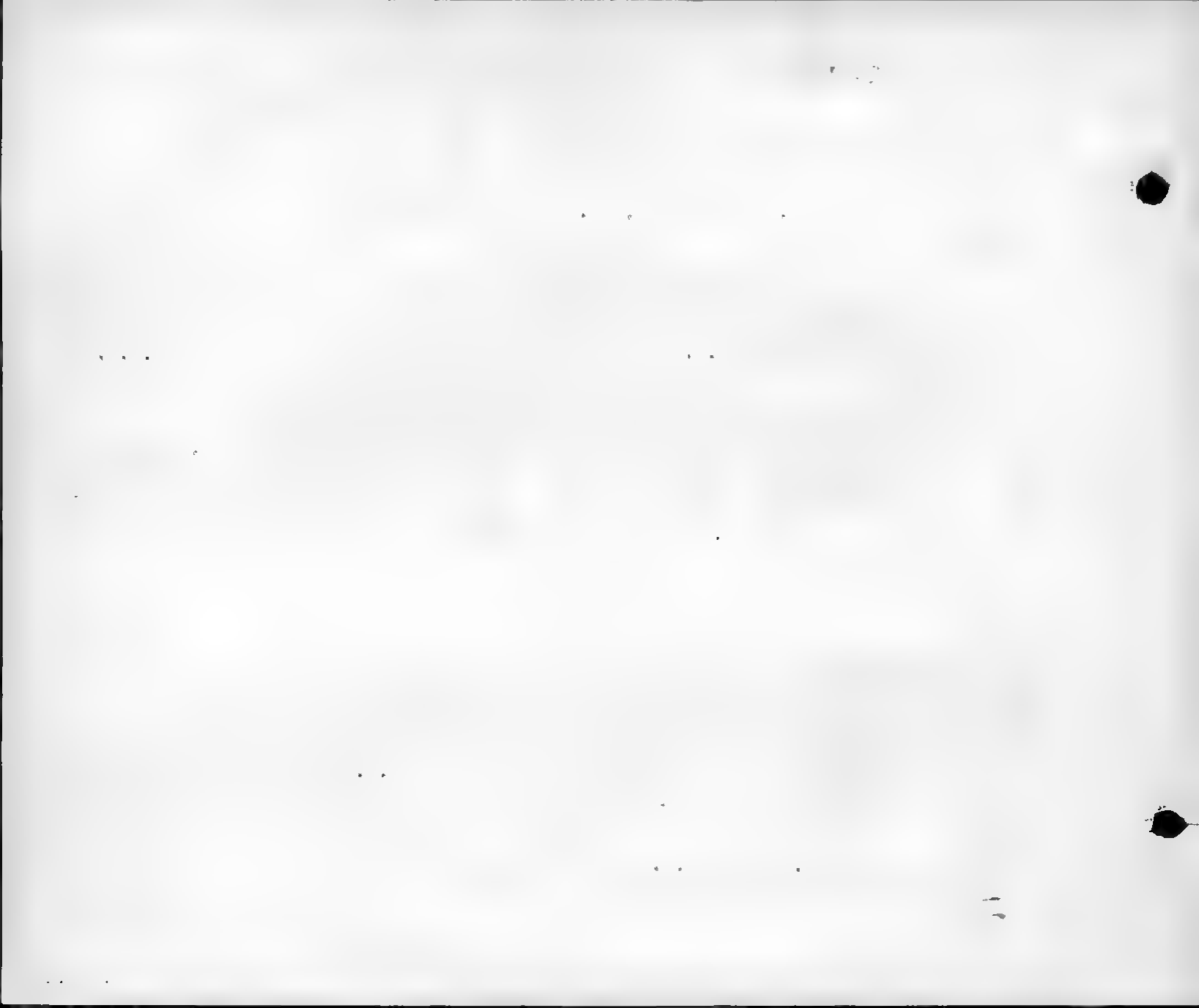
Reg. Dist. No.

00915

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. STATE <u>Virginia</u> c. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1919 North Daniel Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Frances</u> Last <u>Pote</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1913</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Management Analyst</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Pote</u>				14. MOTHER'S MAIDEN NAME <u>Anna McKenna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>572-32-4822</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>							<u>2 weeks</u>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							<u>1 1/2 years</u>
(b) <u>Extensive metastatic disease</u>							<u>1 1/2 years</u>
(c) <u>Adenocarcinoma of breast</u>							<u>1 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>October 20, 1960</u> to <u>January 8, 1961</u> , that I last saw the deceased alive on <u>January 8, 1961</u> , and that death occurred at <u>10:45 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michael Z. Lazor</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Michael Z. Lazor, M.D.</u>				DATE SIGNED <u>Jan 11 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/12/61</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>475-H. N. W. Wash.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 11 1961</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

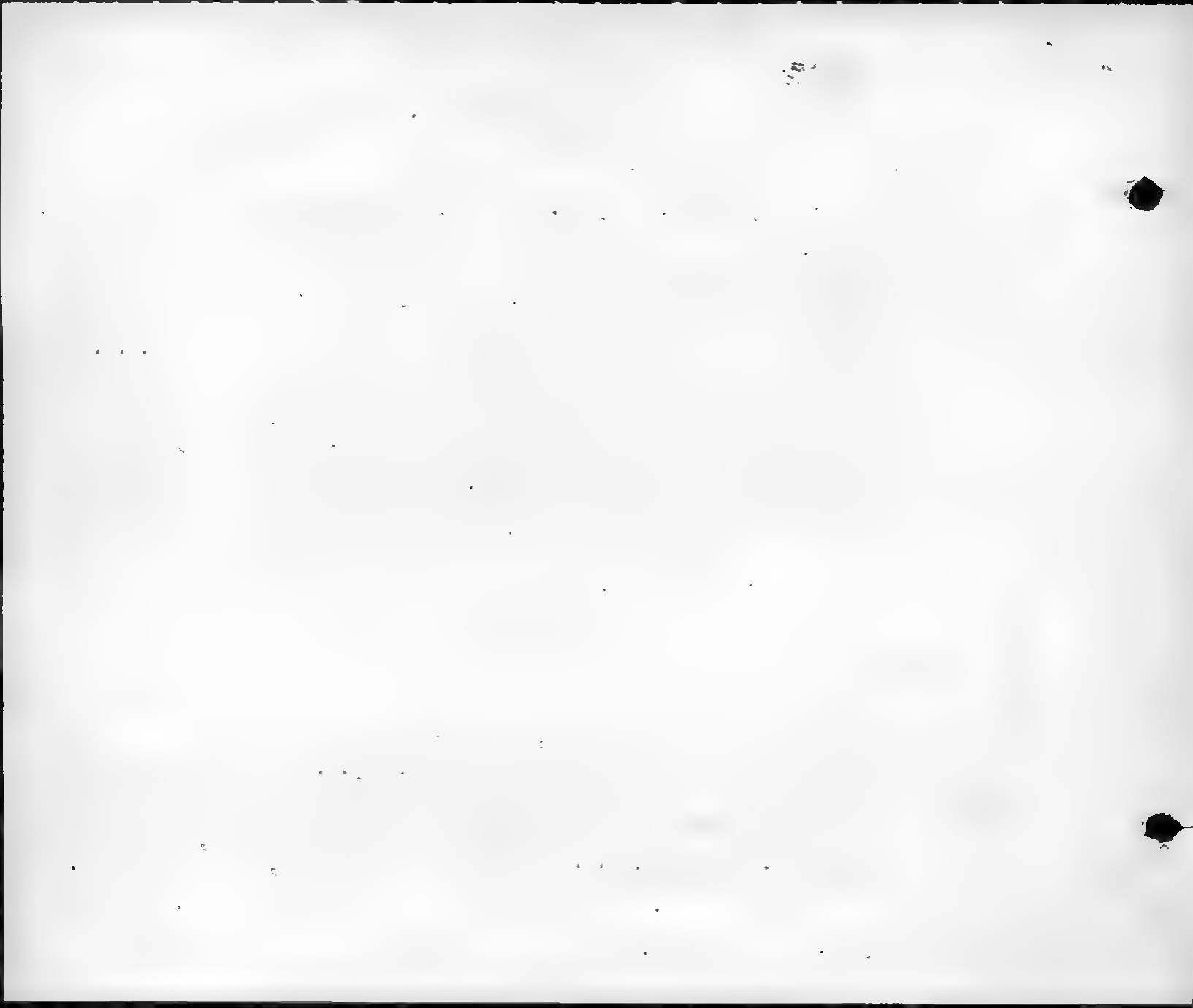
CERTIFICATE OF DEATH

00914

921

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vandling		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 308 Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara Ann Pribula		First Middle Last		4. DATE OF DEATH January 9 1961		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1928		9. AGE (In years last birthday) yrs 32	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Fotusky				14. MOTHER'S MAIDEN NAME Eva Dayton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 169-24-3316		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: 410x IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral Stenosis, Mitral Insufficiency DUE TO (c) Rheumatic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 5 years ? ?
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 5, 1961 , to January 9, 1961 , that (I) (we) last saw the deceased alive on January 9, 1961 , and that death occurred at 11:32 P.M. from the causes and on the date stated above							
22a. SIGNATURE <i>Michael W. Brandriss</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/10/61	
22c. PHYSICIAN'S NAME (Type) Michael W. Brandriss, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/14/61		23c. NAME OF CEMETERY OR CREMATORY St. Agnes Cemetery		23d. LOCATION (City, town, or county) (State) Susquehanna Co. Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JAN 11 '61	
				25b. REGISTRAR'S SIGNATURE <i>C. S. Pumphrey</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

66915

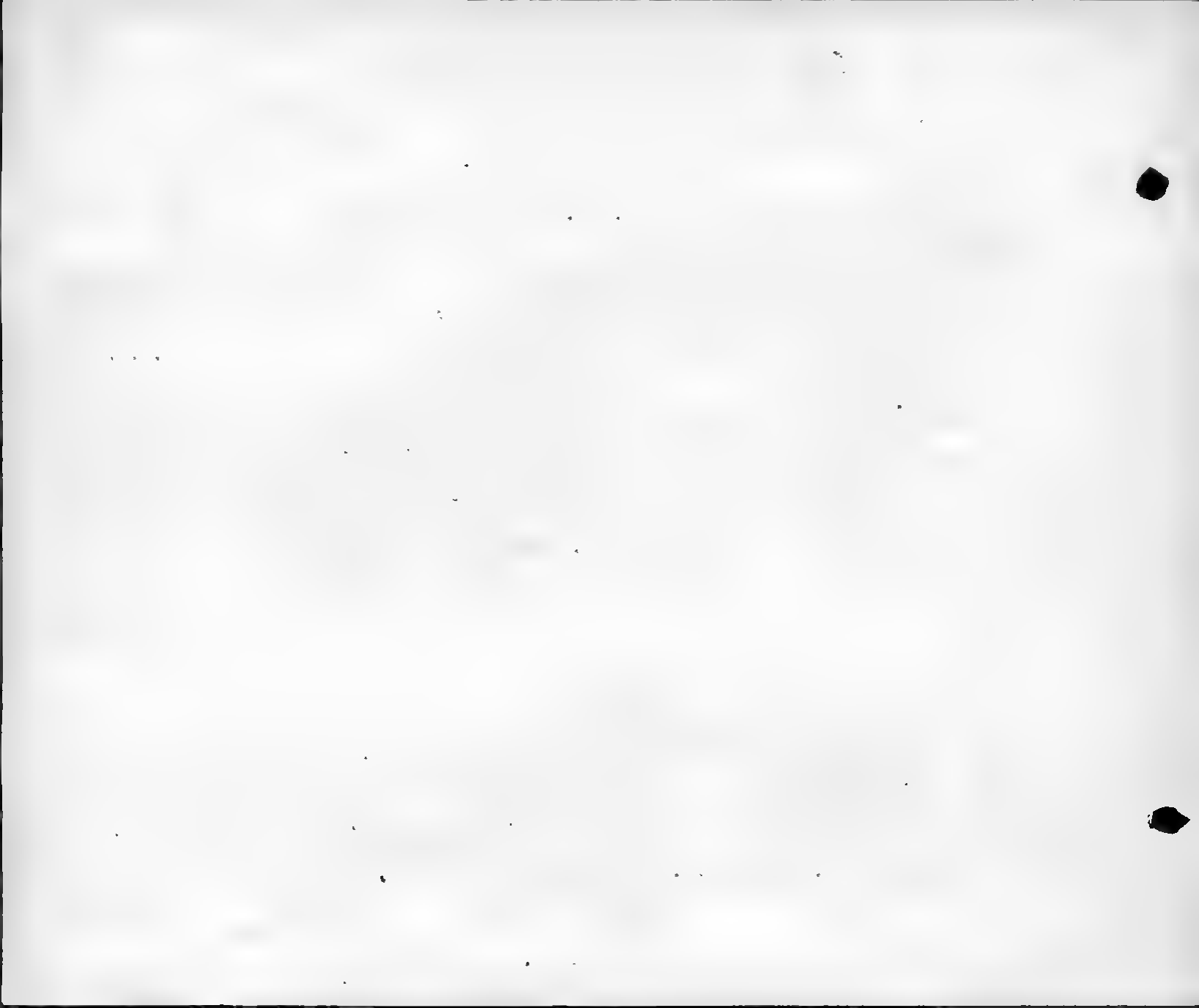
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carol Middle Lynn Last Price		4. DATE OF DEATH Month January Day 7 Year 19 61		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 8, 1958		9. AGE (In years last birthday) 2 yrs		IF UNDER 1 YEAR Months 7 Days 19 Hours 61 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold H. Price		14. MOTHER'S MAIDEN NAME Barbara De Grange					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary and gastro-intestinal hemorrhage DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO b) Acute lymphatic leukemia (c) _____							
INTERVAL BETWEEN ONSET AND DEATH days 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 29, 1960 , to January 7, 1961 , that I last saw the deceased alive on January 7, 1961 , and that death occurred at 12:45 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/7/61 ACTUAL SIGNATURE Jerome B. Block M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Jerome B. Block, M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/1961		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter - Houzer Funeral Home				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JAN 9 '61	
				24b. REGISTRAR'S SIGNATURE C. J. A. [Signature]			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de-
necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash. San + Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 19102 Warren St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Mary Elizabeth Principle

4. DATE OF DEATH 1-12-61
Month 1 Day 12 Year 1961

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH February 25 1918
9. AGE (In years last birthday) 42
Months 0 Days 0 Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) U.S. Gov't.
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Bluefield West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Perry Graham
14. MOTHER'S MAIDEN NAME Elizabeth Mary Spurrier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
16. SOCIAL SECURITY NO. yes
17. INFORMANT Mr. Claude Principle
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PENDING DUE TO Barbiturate poisoning
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

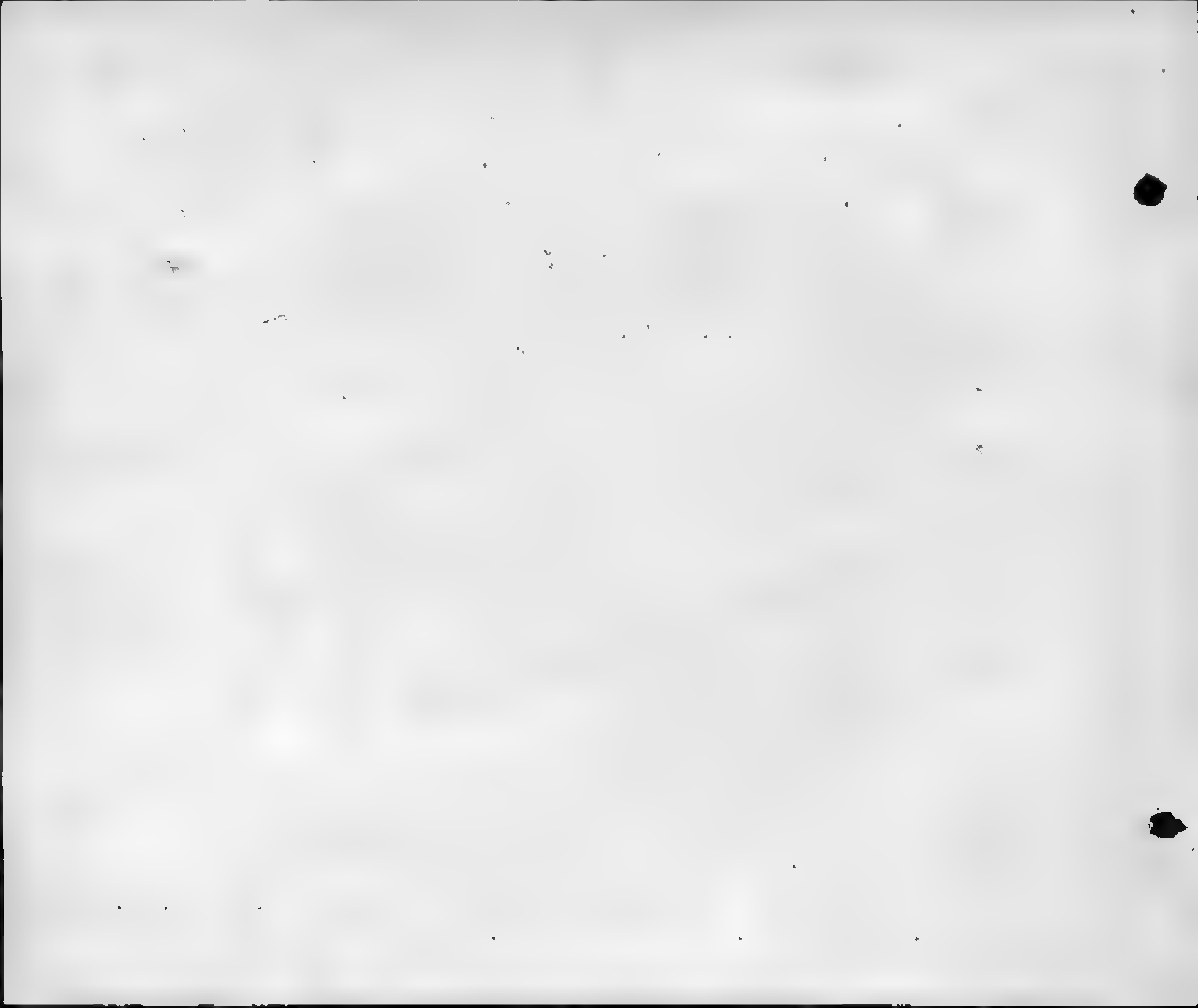
20c. TIME OF INJURY Month, Day, Year 19
Hour a.m. p.m.
20d. INJURY OCCURRED While ☐ Not While ☐
at work ☐ at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Blaszczak M.D.
EXAMINER'S NAME (Type) FRANK J. BLASZCZAK
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) 1-12-61

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 1/16/61
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY
22d. LOCATION (City, town, or country) (State) PRINCE GEO. COUNTY, MD.

23. FUNERAL DIRECTOR RAYMOND E. GUSTAK ADDRESS SILVER SPRING, MD.
24a. REC'D BY REGISTRAR JAN 17 '61
24b. REGISTRAR'S SIGNATURE Charles S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

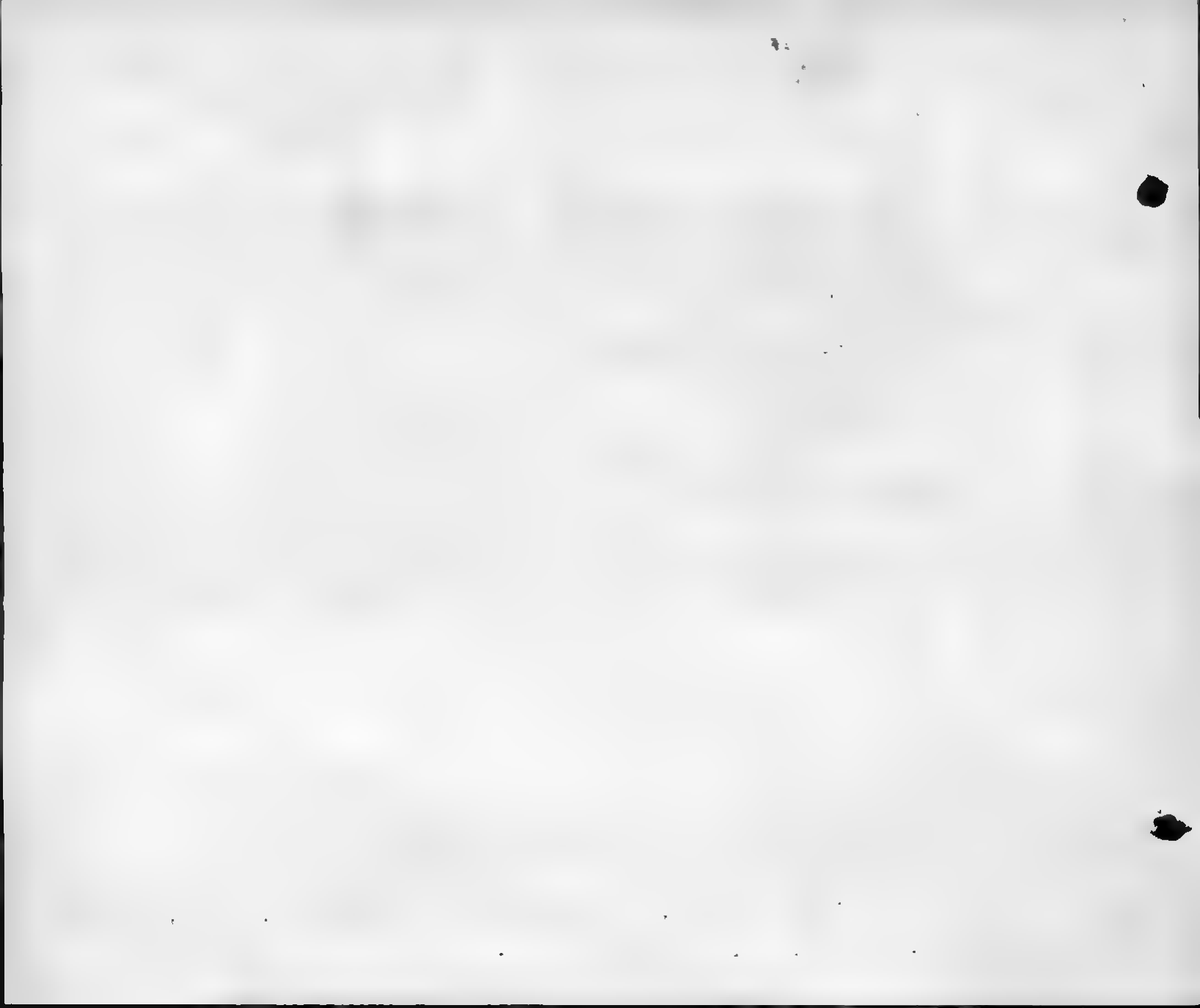
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

924

00917

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>27 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> d. STREET ADDRESS <u>12609 Littleton St.</u>	
3. NAME OF DECEASED (Type or print) <u>James (NMI) Ramsay</u>		4. DATE OF DEATH Last <u>Jan.</u> Month <u>7</u> Day <u>1961</u> Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>11-19-85</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>61</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant-Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Riggs Market</u>	
11. BIRTHPLACE County & State, or foreign country <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Alexander Ramsay</u>		14. MOTHER'S MAIDEN NAME <u>Mary unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IN IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>420.5</u> DUE TO (b) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last <u>Arteriosclerosis, etc. Heart Disease</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>16 Hours</u> <u>27 Days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia and Complications of Heart Failure</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER). YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-11-1961 to 1-7-1961, that (I) (we) last saw the deceased alive on 1-6-1961, and that death occurred at 12:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>1-7-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>		22d. ADDRESS ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d. LOCATION City, town or county (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>JAN 12 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

925

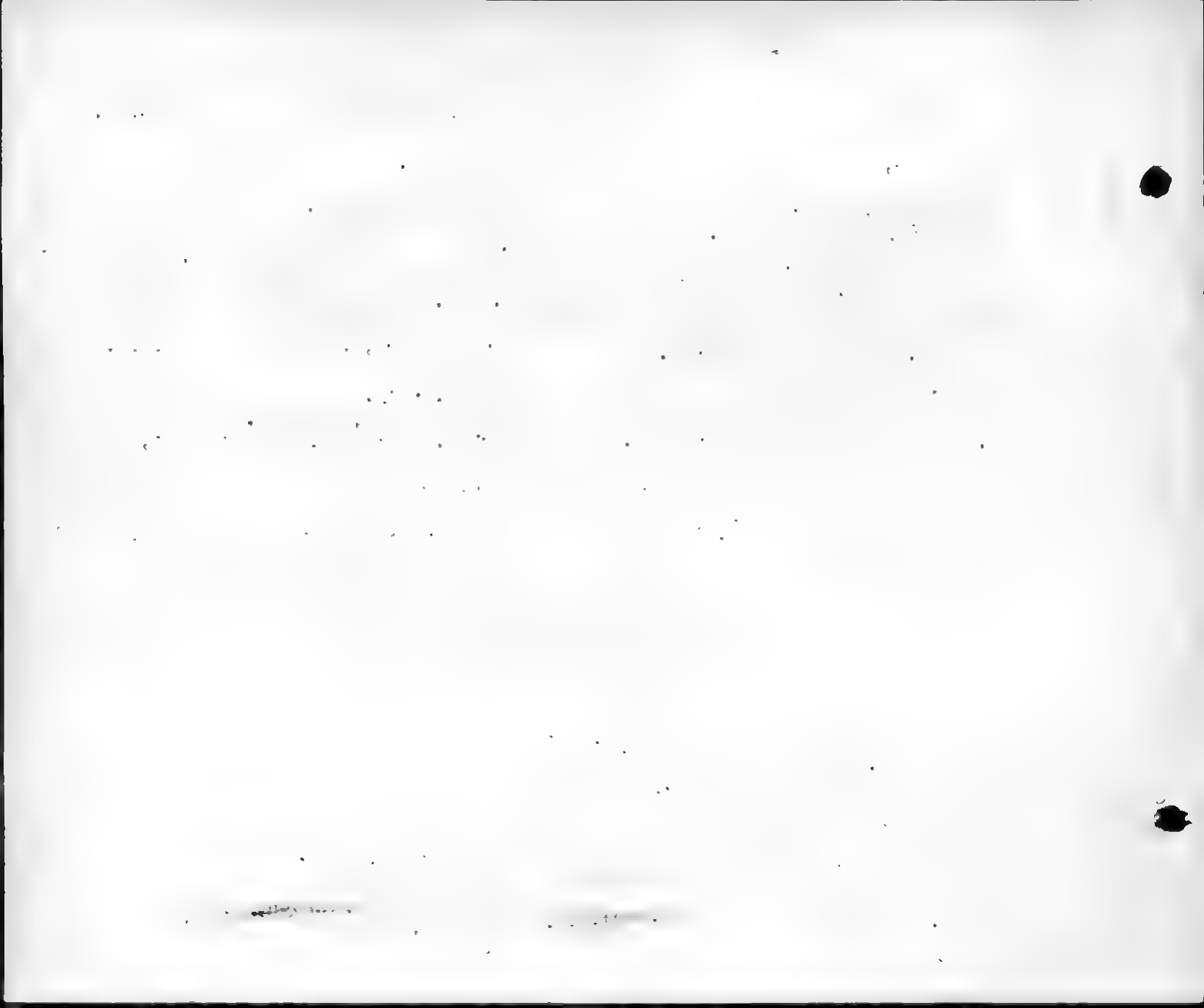
CERTIFICATE OF DEATH

Reg. Dist. No.

00918

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 702 Burgundy Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Annabel Eva Range. Middle Last Range				4. DATE OF DEATH January 16th. 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11th. 1920	9. AGE (In years last birthday) 40 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk.		10b. KIND OF BUSINESS OR INDUSTRY Bank.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Arendes				14. MOTHER'S MAIDEN NAME Anna F. Nally.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO. Unknown.		INFORMANT Rockville, Maryland. Address Fredrick P. Range 702 Burgundy Drive,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Carcinoma of Lungs Primary (c) DUE TO 10 months						INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from March 1960 to Jan 16 1961 , that I last saw the deceased alive on Jan 8 1961 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis J. Sharpe M.D.		ADDRESS (Street, city or town, state) 3323 - 0-4th Ave.		DATE SIGNED 1-16-61			
PHYSICIAN'S NAME (Type) Francis J. Sharpe		LOCATION (City, town or county) (State) Washington 7, D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial.	22b. DATE THEREOF 1/19/61	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town or county) (State) Washington, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Bickelmeier		ADDRESS 3034 14th St NW		24. REGISTRAR'S SIGNATURE Jan 19 '61			

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15M 9/60

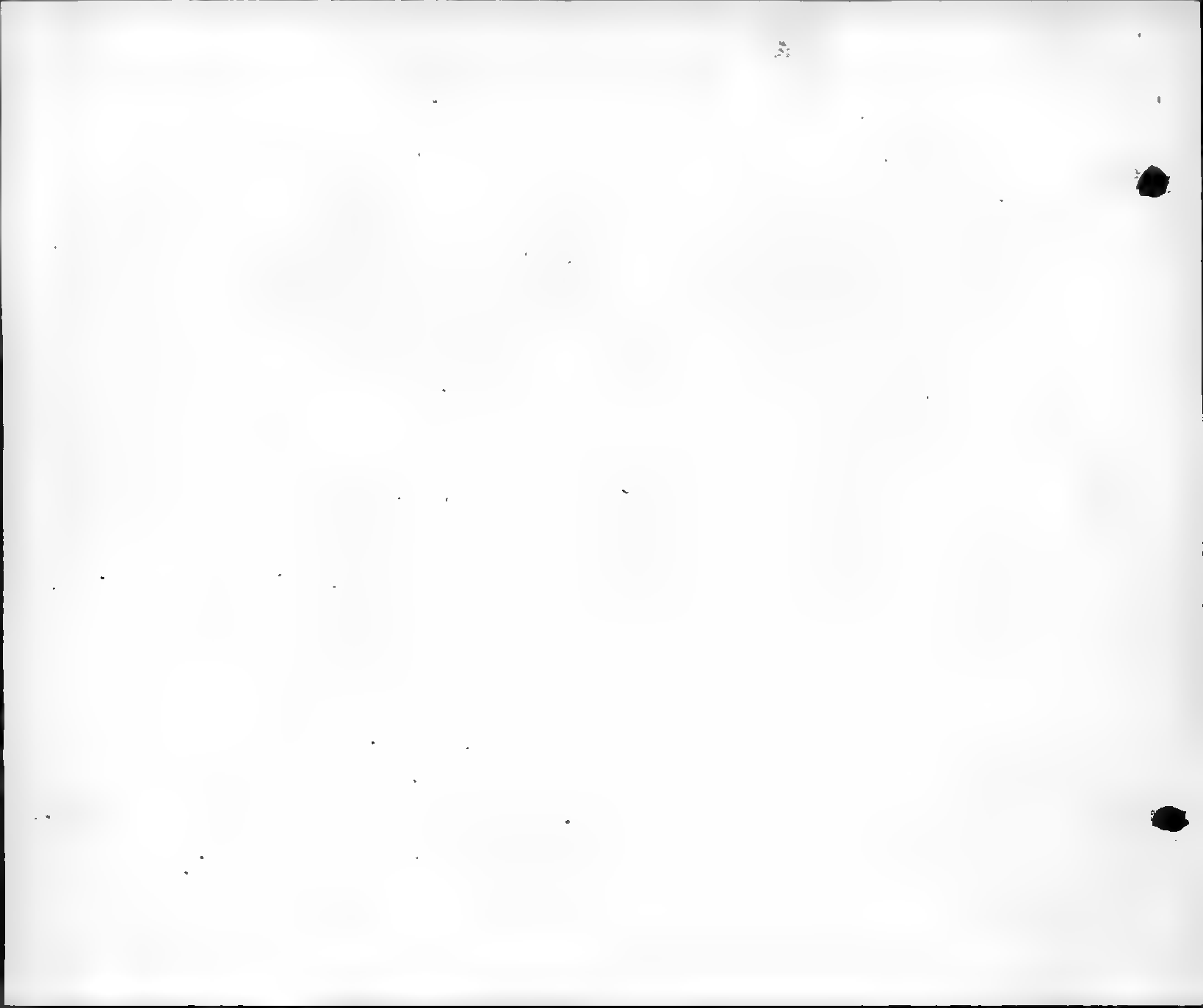
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

926

66919

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SAN. & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12001 Colesville Rd</u>	
3. NAME OF DECEASED (Type or print) <u>George Charles Richert</u> First Middle Last		4. DATE OF DEATH <u>1 - 20 1961</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-04</u> Last First Middle
9. AGE (In years last birthday) <u>57</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.		10. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Assoc</u>	
11. FATHER'S NAME <u>Charles Richert</u>		12. MOTHER'S MAIDEN NAME <u>Magdalene Good</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		14. SOCIAL SECURITY NO. <u>168-05-0070</u>	
15. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>434</u> DUE TO <u>Cardiac Distention</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		16. INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 10, 1940 to Jan 20, 1961, that (I) (we) last saw the deceased alive on Jan 18, 1961, and that death occurred at 8:45 AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. B. Lardrop M.D.</u>		22b. DATE SIGNED <u>1/20/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. B. Lardrop M.D.</u>		22d. ADDRESS <u>8000 Pershing Ave. Detroit, Mich.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		23b. DATE THEREOF <u>1/24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>RICHLAND CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>DRYSDALE, PENNSYLVANIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Lardrop M.D.</u>		25a. REC'D BY REGISTRAR <u>JAN 25 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			





928

CERTIFICATE OF DEATH

Reg. Dist. No. 00921

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 ROCKVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,610 PARKLAND DRIVE				d STREET ADDRESS 12,610 PARKLAND DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) MAY ESTELLE RODGERS				4. DATE OF DEATH JANUARY 17 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/17/1900	
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM E. SMITH				14. MOTHER'S MAIDEN NAME CATHERINE CULLEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO				16. SOCIAL SECURITY NO NONE			
17. INFORMANT Mr. Keith R. Rodgers, 12,610 Parkland Drive				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 175 c DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OVARIAN ADENOCARCINOMA DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 MOS. 8 MOS.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JUNE 1957 to JAN. 17, 1961 that I last saw the deceased alive on JANUARY 13, 1961, and that death occurred at 2:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11502 Grandview Ave. 1/17/61 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) RALPH R. REAP, M.D. SILVER SPRING, MARYLAND							
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/20/61		22c. NAME OF CEMETERY OR CREMATORY NAT'L. MEM. PARK CEMETERY		22d. LOCATION (City, town, or county) (State) FALLS CHURCH, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Raymond E. Glick SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE JAN 25 '61		24b. REGISTRAR'S SIGNATURE Orlana S. Kiana	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOX
HEAL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3M

STATE
TH DEPT.

4 may be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or transportation, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

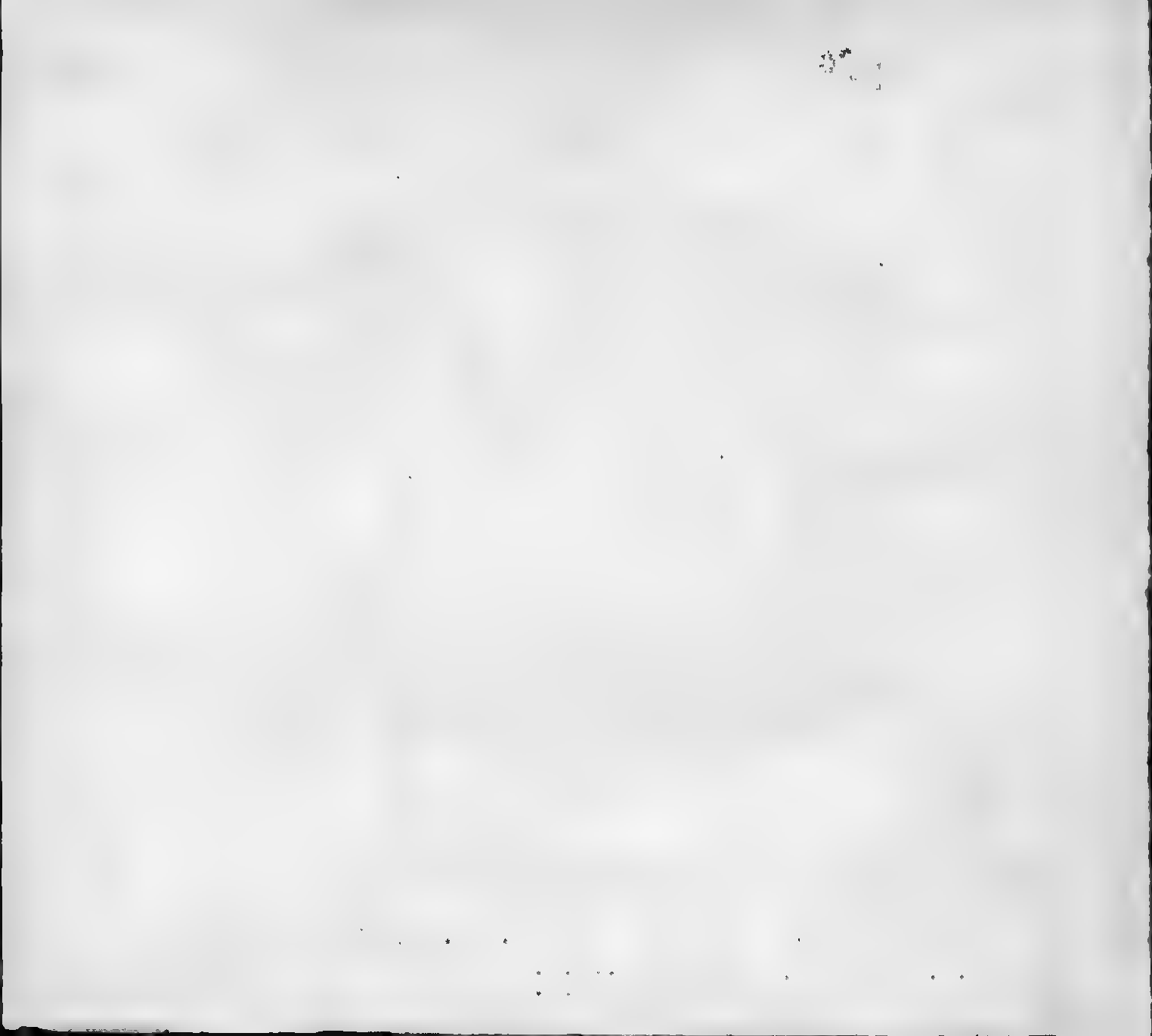
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

929 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66922

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
c. LENGTH OF STAY IN 1b <u>15 yr</u>		d. STREET ADDRESS <u>4501 Cortland Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4501 Cortland Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) <u>Edwin Jehu Rose</u>		4. DATE OF DEATH <u>Jan 5 1961</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-9-1887</u>	
9. AGE (in years) <u>73</u> IF UNDER 1 YEAR IF UNDER 24 HRS		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Desmond Rose</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Wiseman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 1917-1920	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Ruth Rose</u> Address <u>Ilum 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> DUE TO <u></u> (a), stating the underlying cause last, (c) <u></u> DUE TO <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-5-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/9/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Com.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>JAN 9 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION



1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

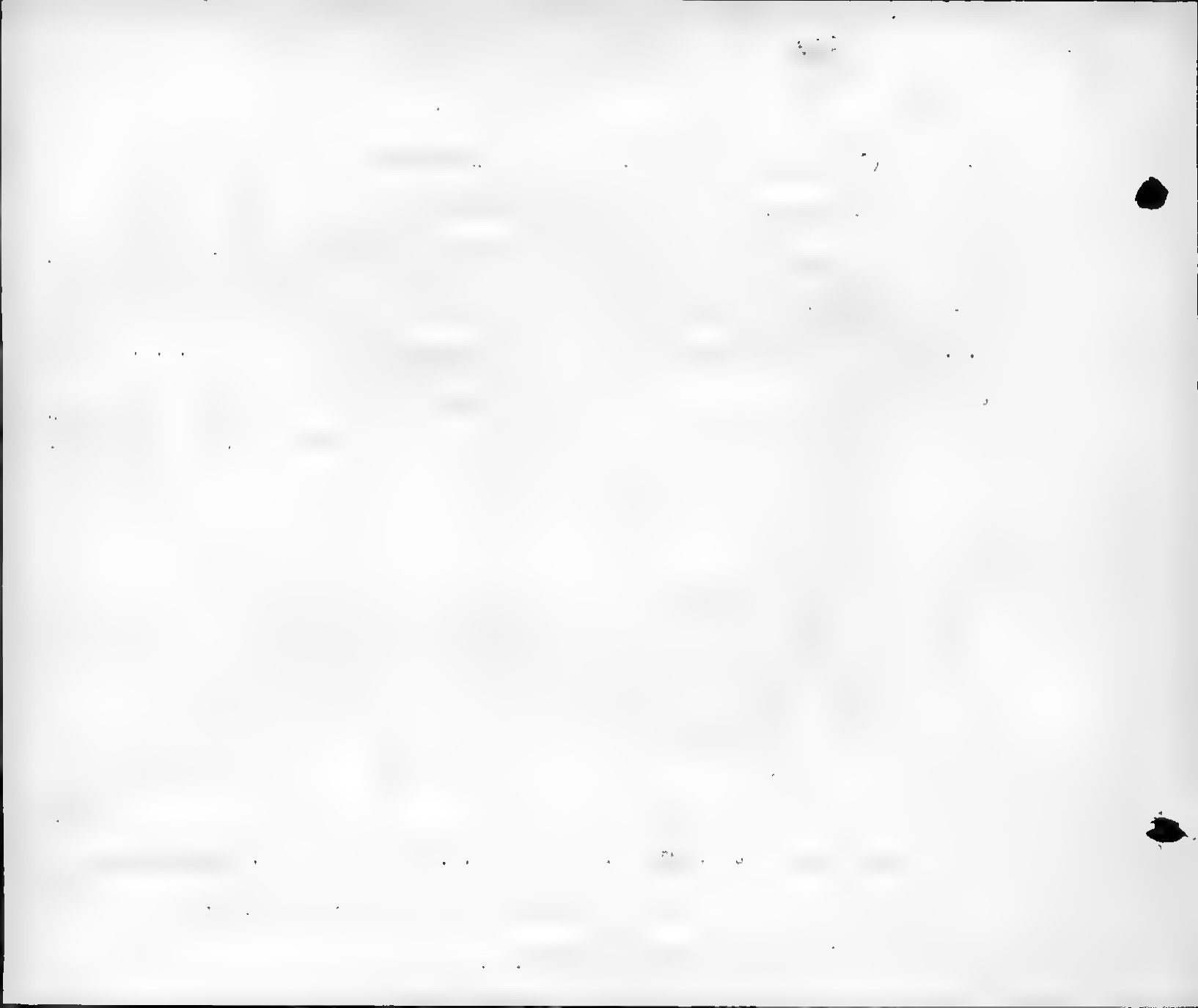
930

CERTIFICATE OF DEATH

60923

Item 9 Film 62-1 2-1-61 et

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethany Beach d. STREET ADDRESS PO Box 29 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last James Boyd RUTTER		4. DATE OF DEATH Month Day Year January 29 1961	
5. SEX Male	6 COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-20-87
9 AGE (In years last birthday) 73 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy	10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James C. RUTTER		14. MOTHER'S MAIDEN NAME Harriet M. Mc KELVY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1905-45	
17. INFORMANT Mrs. James Rutter, PO Box 29, Bethany Beach,		Add Delaware	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Years		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-9 to 1-29 , 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1-29 , 1961 , and that death occurred 1150AM from the causes and on the date stated above.			
22a. SIGNATURE Russell Miller Jr., M.D.		22b. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
22c. PHYSICIAN'S NAME (Type) Russell Miller Jr., LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-2-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlers and Sons Inc.		25a. REC'D BY REGISTRAR DATE FEB 2 '61	
ADDRESS 1756 Penn. Ave. Washington 6, D. C.		25b. REGISTRAR'S SIGNATURE Arthur S. House	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

931

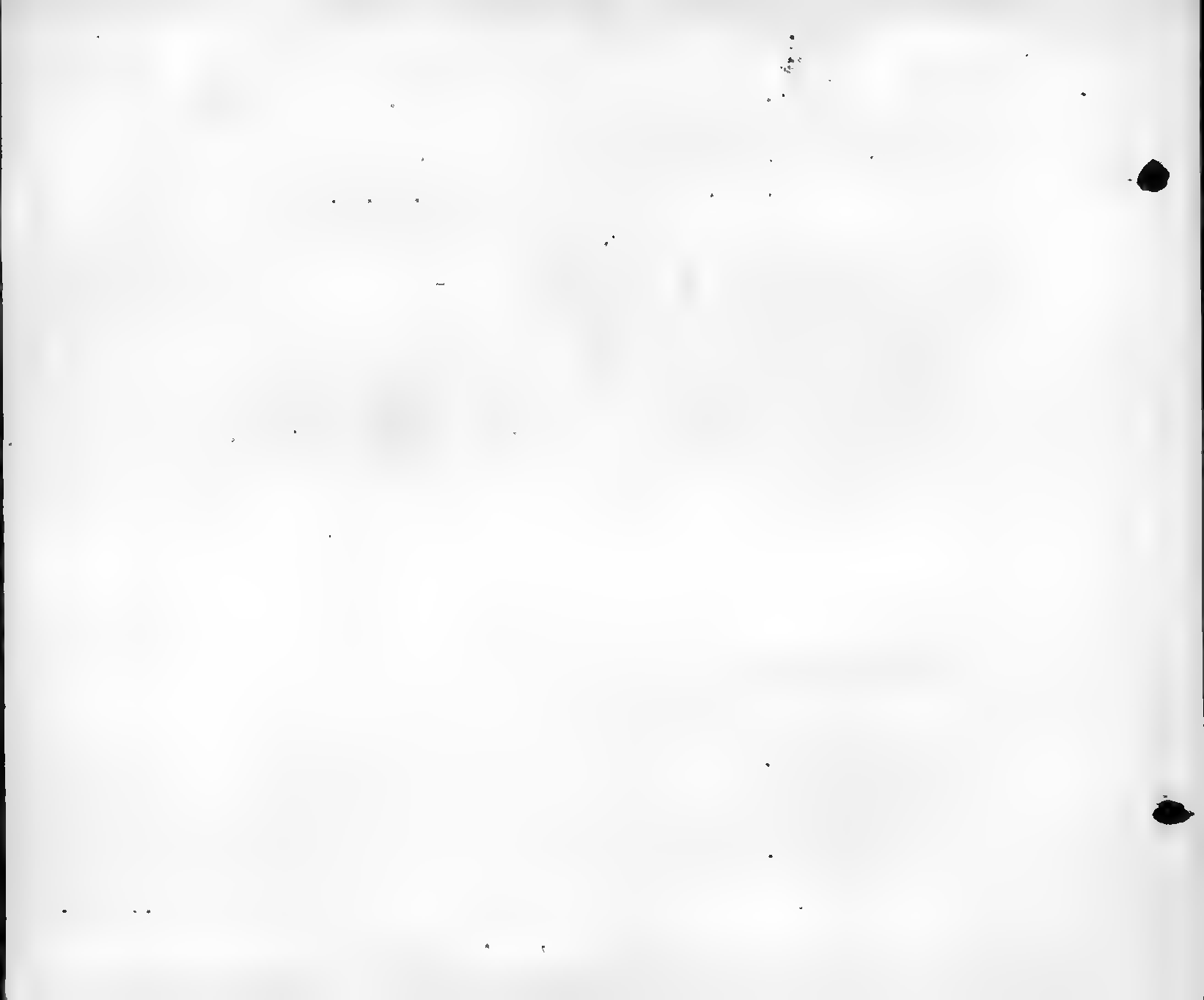
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00924

1. PLACE OF DEATH a. COUNTY Montgomery Md. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE New York b. COUNTY Tompkins	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Silver Spring-Wheaton		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11901 Ga. Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ithaca	
3. NAME OF DECEASED (Type or print) George First H. Middle Sabine Last		4. DATE OF DEATH Month 1 Day 18 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-1880
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Lorenzo Sabine		14. MOTHER'S MAIDEN NAME Eva Mary Tuttle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Mrs. Mary Sabine		Address 7007 Ga. S. Chevy Chase Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 180 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic lymphoma DUE TO (c) 2 months		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 4 19 61 , to Jan 18 19 61 , that (I) (we) last saw the deceased alive on Jan 17 19 61 , and that death occurred at 2:55 P. M., from the causes and on the date stated above			
22a. SIGNATURE Seruch T. Kimble		22b. DATE SIGNED Jan 18, 1961	
22c. PHYSICIAN'S NAME (Type) SERUCH T. KIMBLE		22d. ADDRESS 929 Plant. Rd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 1-19-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE A. Humphrey Funeral Home		25a. REC'D BY REGISTRAR DATE JAN 23 '61	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kim	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66925

932

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 97 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
f. STREET ADDRESS #3 Helm Green, S. W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eugenia Middle SANES Last SANES				4. DATE OF DEATH Month January Day 16 Year 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2-12-10	
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min 50		11. IF UNDER 24 HRS Months 50 Days 50 Hours 50 Min 50		12. C.T.ZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY - - - - -			
11. BIRTHPLACE (State or foreign country) Puerto Rico				12. C.T.ZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Balitinia AYALA				14. MOTHER'S MAIDEN NAME Leona SANES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT (D) Mrs. Delbert Gibson, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia							
DUE TO 1741							
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) Metastatic squamous cell CARCINOMA 2 yr							
(c) Sq. cell carcinoma lower uterus 3 yr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 11, 1960 to Jan. 16, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 16, 1961 , and that death occurred at 2:40 AM , from the causes and on the date stated above.							
22a. SIGNATURE R. F. Mading							
22b. DATE SIGNED 1-16-61							
22c. PHYSICIAN'S NAME (Type) R. F. MADING, LT, MC, USN							
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
23b. DATE THEREOF 1-19-61							
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet							
23d. LOCATION (City, town, or county) (State) Washington, D. C.							
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. McQuinn							
25a. REC'D BY REGISTRAR JAN 19 61							
25b. REGISTRAR'S SIGNATURE Carl E. McQuinn							
25c. ADDRESS 1820 9th St., NW, WashDC							

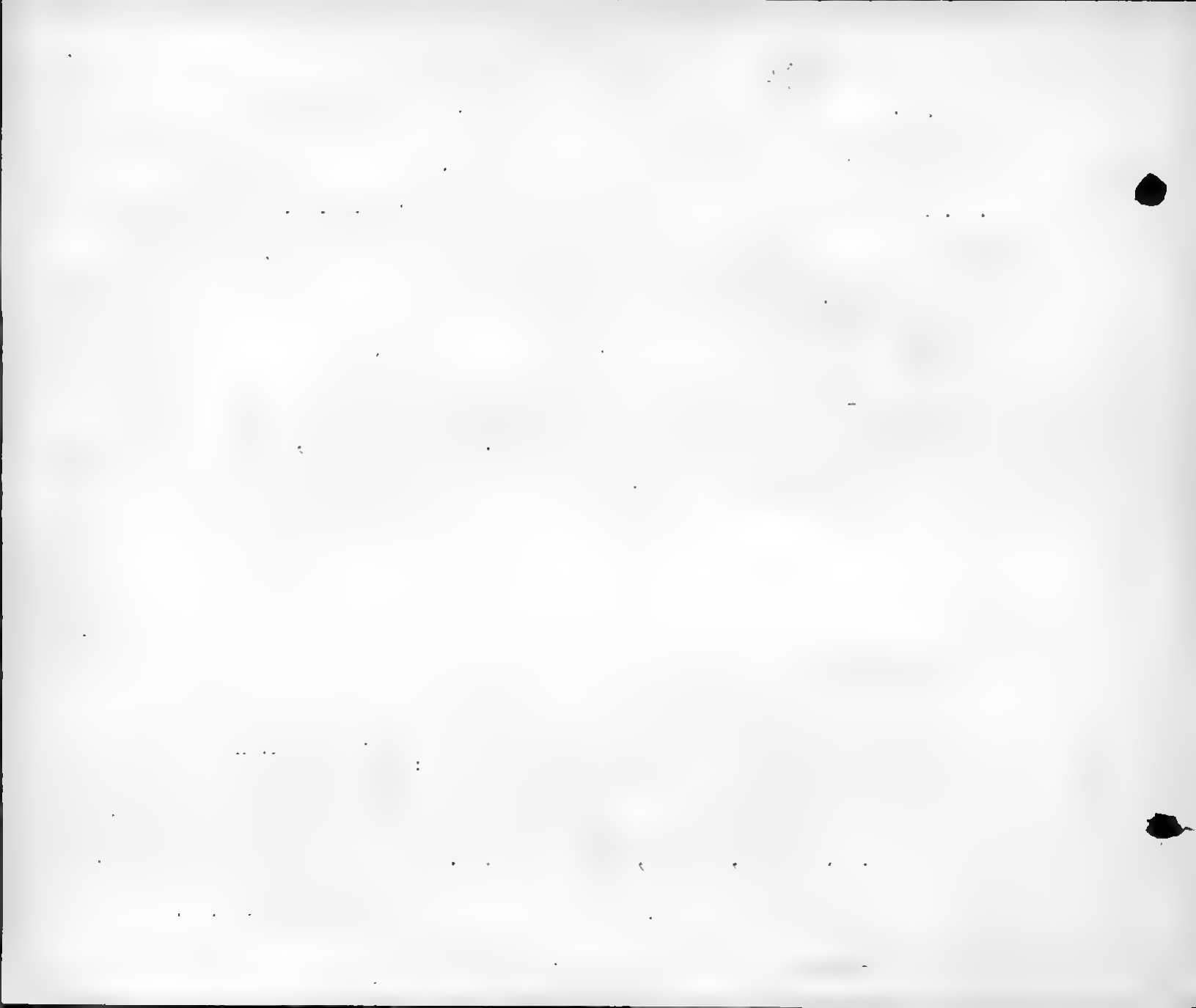
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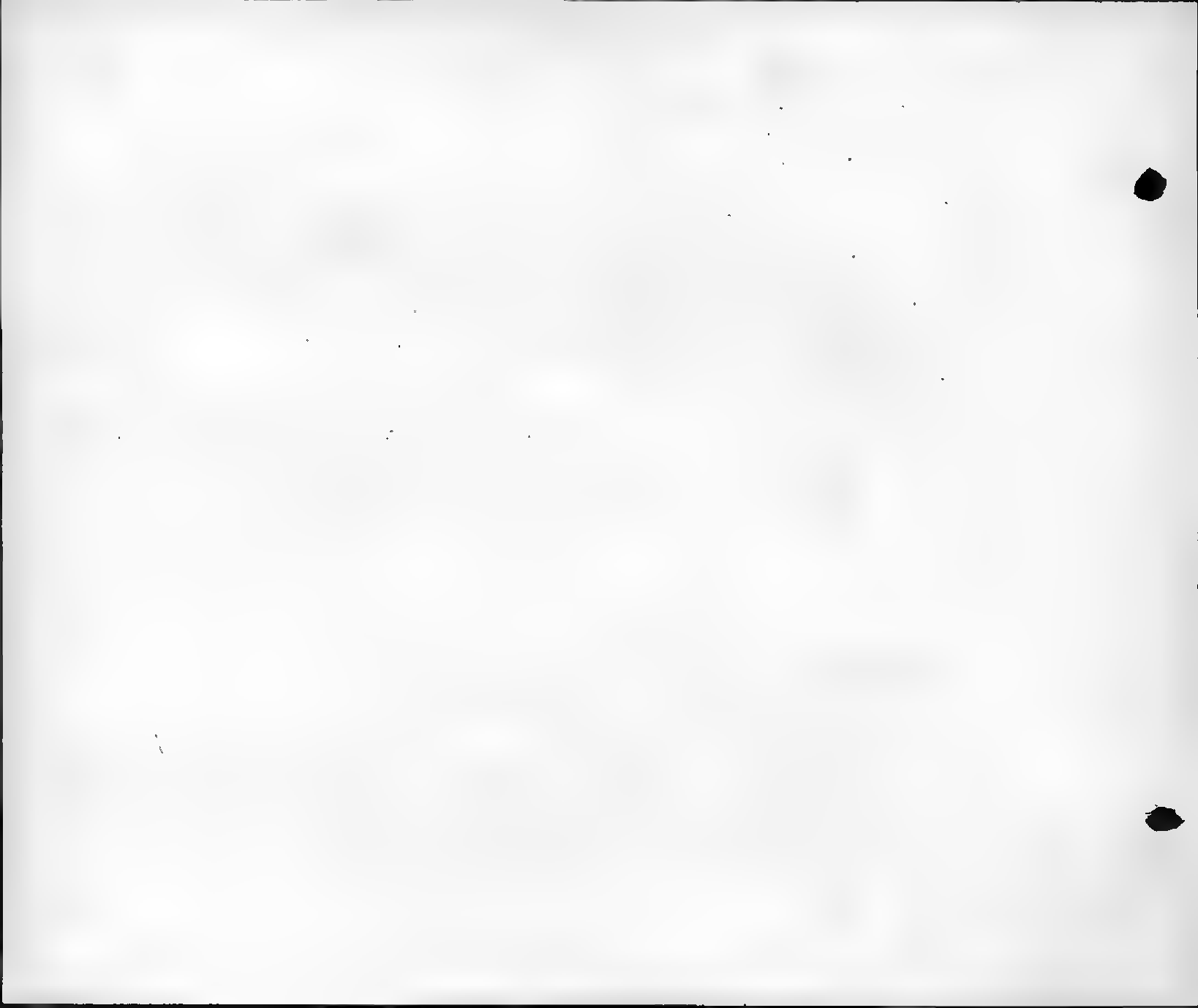
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66926

933

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakons Park</u>				c. LENGTH OF STAY IN 1b <u>years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8011 Glenside Drive</u>				d. STREET ADDRESS <u>8011 Glenside Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISA ALBERTA SAXTON</u>				4. DATE OF DEATH Month Day Year <u>Jan 28 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1867</u>	9. AGE (In years last birthday) <u>93</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Port Huron, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Jelbart</u>				14. MOTHER'S MAIDEN NAME <u>Ann Exx</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs. Anna Hafford (same as #2)</u> Address			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bunch pneumonia</u> <u>471X</u> DUE TO — <u>Hypertension & congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>facture</u> (c) <u>fracture</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>Pneumonia</u> <u>fracture</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(obesity, smoking)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/1/50</u> to <u>1/28/61</u> that (I) (we) last saw the deceased alive on <u>1/27/61</u> and that death occurred at <u>11:27</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Chas H. Stobbs, MD</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Chas H. Stobbs</u>		22d. ADDRESS <u>500 Underwood St. NW. Wash. DC</u>					
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>Jan. 31, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St. Wash. DC</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kears</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

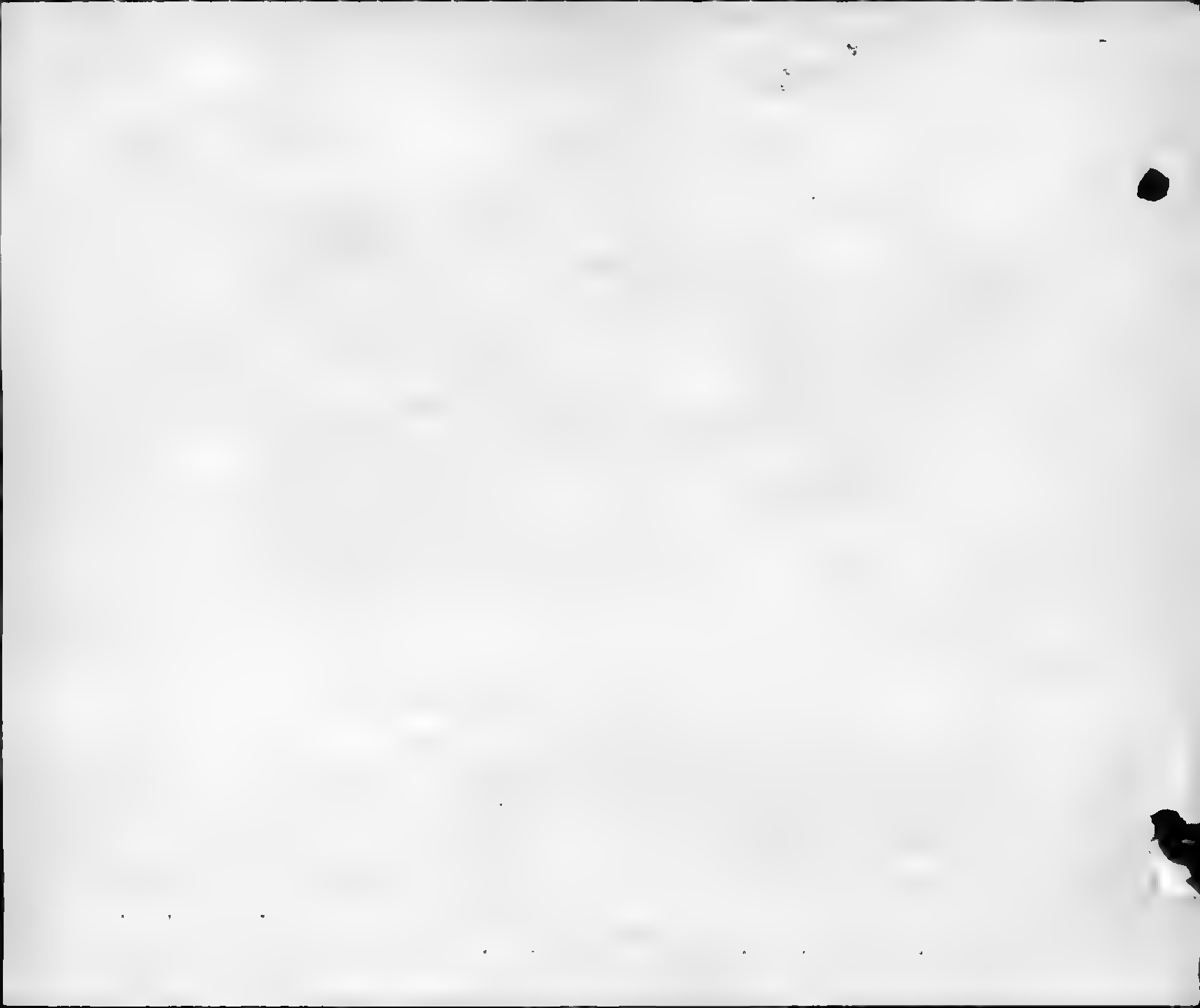
CERTIFICATE OF DEATH

934

60927

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>11 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sen. and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>611 Woodside Parkway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>EARL</u> Last <u>Schmidt</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/25/176</u>					
9. AGE (In years last birthday) <u>84</u> yrs <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u>8</u> Days <u>4</u></td> <td>Hours <u>15</u> Min. <u>0</u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>8</u> Days <u>4</u>	Hours <u>15</u> Min. <u>0</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months <u>8</u> Days <u>4</u>	Hours <u>15</u> Min. <u>0</u>						
13. FATHER'S NAME <u>William Bobb</u>		14. MOTHER'S MAIDEN NAME <u>unknown Pennypacker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>					
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile arteriosclerotic Heart Disease</u> DUE TO (c) <u>Senile arteriosclerotic Heart Disease</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary embolism, Hydatid Cyst, Sore Throat, etc.</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER!) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>5/14/1960</u> to <u>1/15/1961</u>, that (I) <u>no</u> last saw the deceased alive on <u>1/15/1961</u>, and that death occurred at <u>10:16</u> A.M. from the causes and on the date stated above							
22a. SIGNATURE <u>Russell B. Arnold</u>		22b. DATE SIGNED <u>1/15/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>Russell B Arnold M.D.</u>		22d. ADDRESS <u>8801 Cobsville Road, Silver Spring, Md.</u>					
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/19/61</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>WABNER E. PUMPHREY, INC.</u>		25. REC'D BY REGISTRAR DATE <u>JAN 25 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.
M

MARYLAND STATE DEPARTMENT OF HEALTH

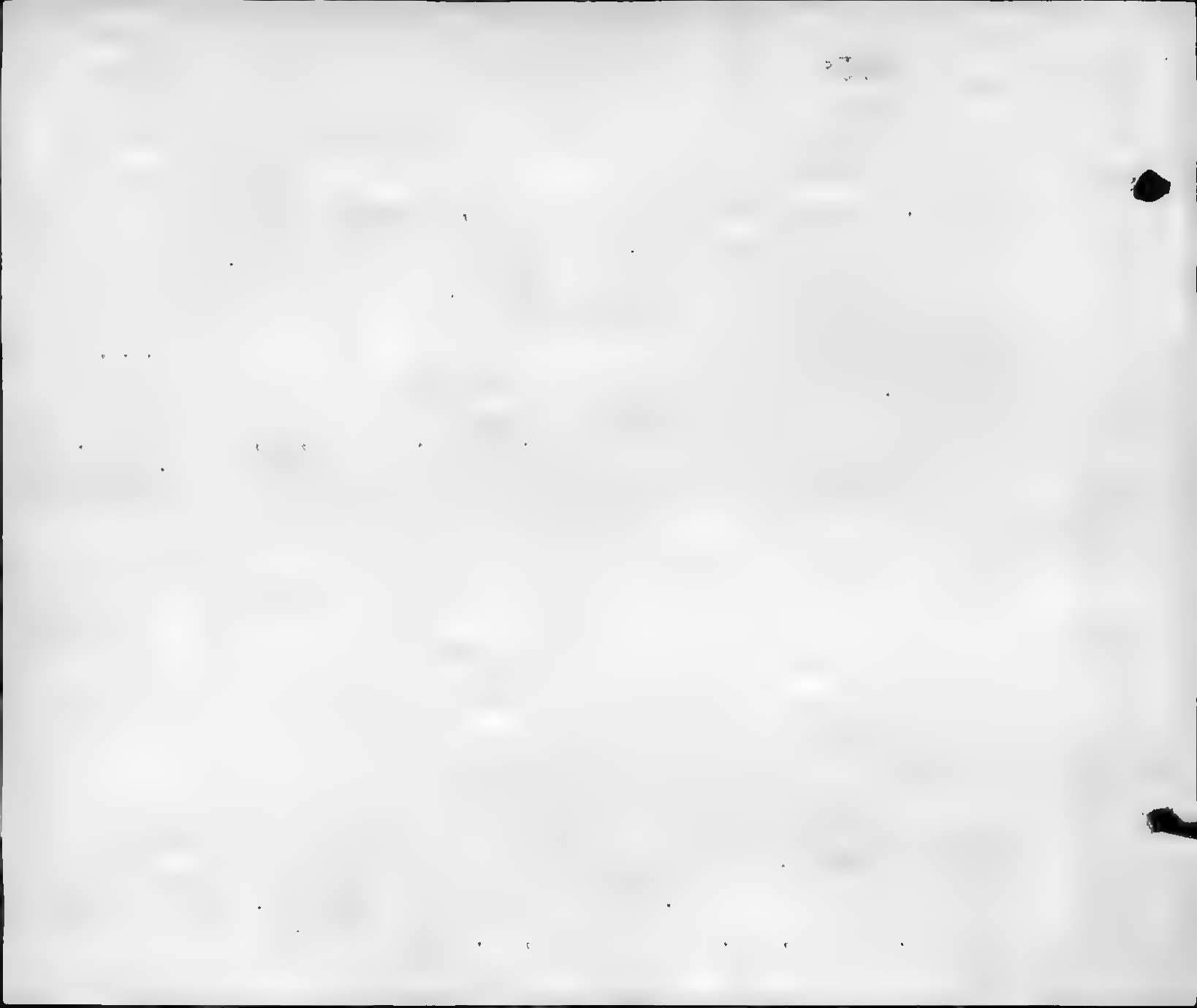
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

935 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00928

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN TOWN 5 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10,124 RENFREW ROAD			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 10,124 RENFREW ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARTIN First Albert Middle SCHWARTZ Last			4. DATE OF DEATH Month JAN. Day 6 Year 1961		
5. SEX MALE			6. COLOR OR RACE WHITE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 11/29/84		
9. AGE (In years last birthday) 76 yrs.			10. AGE (In years last birthday) 76 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector RETIRED			10b. KIND OF BUSINESS OR INDUSTRY C & Milwaukee RAILROAD		
11. BIRTHPLACE (State or foreign country) IOWA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME MARTIN J. SCHWARTZ			14. MOTHER'S MAIDEN NAME EMMA MOECKLI		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) NO			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT Mrs. Selma I. Schwartz, 10,124 Renfrew Rd. Silver Spring, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) SILVER SPRING, MD. (a), stating the underlying cause last. (c) SUDDEN			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart			CHIEF MEDICAL EXAMINER		
EXAMINER'S NAME (Type) FRANK J. BROSCHART			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DATE SIGNED 1/6/61		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 1/9/61		
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY			22d. LOCATION (City, town, or country) (State) PRINCE GEO. COUNTY, MARYLAND		
23. FUNERAL DIRECTOR WERNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.			24a. REC'D BY REGISTRAR JAN 11 '61		
24b. REGISTRAR'S SIGNATURE Arthur L. House					

VS. A15ME
5M 7/59



936

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM</u>		e. STREET ADDRESS <u>1727 ARGYLE ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALTON RAY</u>		4. DATE OF DEATH Month Day Year <u>1-11-61</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/1960</u>
9. AGE (In years last birthday) <u>1</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <u>1</u> <u>0</u> <u>0</u> <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>TAKOMA PARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Max Sellers</u>		14. MOTHER'S MAIDEN NAME <u>Jacqueline Ginn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Patients Chart.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity - Respiratory Failure</u> 77-25 DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 26, 1960</u> to <u>Jan 7, 1961</u> , that I last saw the deceased alive on <u>Jan 31, 1961</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Walter E. Meyer MD</u>		ADDRESS (Street, city or town, state) <u>5323 Highland Ave T.L. P. 61</u>	
PHYSICIAN'S NAME (Type) <u>Walter E. Meyer MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 4, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Heights Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arden Heights, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St. NW.</u>	
24a. REC'D BY REGISTRAR <u>Jan 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiser</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60930

937

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Be the sda.</u>			c. LENGTH OF STAY IN TB <u>11 days.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>			e. STREET ADDRESS <u>8303 - Colesville Rd</u>		
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>CORDELIA</u> Last <u>Shaw</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1961</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 1984</u>		9. AGE (In years last birthday) <u>76</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>William Shaw</u>			14. MOTHER'S MAIDEN NAME <u>XXX ANNE M. FAWCETT</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO <u>NONE</u>		
17. INFORMANT <u>Mrs. Edna L. Shaw</u>			Address <u>21 Shreve St. Silver Spring, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> + 33.1 DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Auricular Fibrillation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> <u>20 yrs.</u> <u>10 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 PREMIA</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 7, 1961</u> to <u>JAN 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>JAN 18, 1961</u> , and that death occurred at <u>4:49 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>George B. Patrick Jr.</u> M.D.			22b. DATE SIGNED <u>1-19-61</u>		
22c. PHYSICIAN'S NAME (Type) <u>George B. Patrick Jr. M.D.</u>			22d. ADDRESS <u>9221 Colesville Silver Spring, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>PRINCE GEO. COUNTY, MARYLAND</u>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Siska</u>			25a. REC'D BY REGISTRAR <u>JAN 25 '61</u>		
25b. REGISTRAR'S SIGNATURE <u>Wm. S. House</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

938

CERTIFICATE OF DEATH

00931

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN MD <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11722 Georgia Ave Wheaton</u> d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Arthur Lawrence Simpson</u>		4. DATE OF DEATH Day <u>17</u> Month <u>Jan</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>9-27-08</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Arthur L. Simpson Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Emma Williams</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records -</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } DUE TO <u> </u> (b) <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from 1/5/52 to 1/17/61, 19....., that (I) (we) last saw the deceased alive on 1/17/61, 19....., and that death occurred at 1:00 PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Patricia Jameson</u>				22b. DATE SIGNED <u>1/17/61</u>			
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 21, 1961</u>		23b. DATE THEREOF <u> </u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			
23d. LOCATION (City, town or county) <u>Suitland Md</u>		(State) <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 23 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



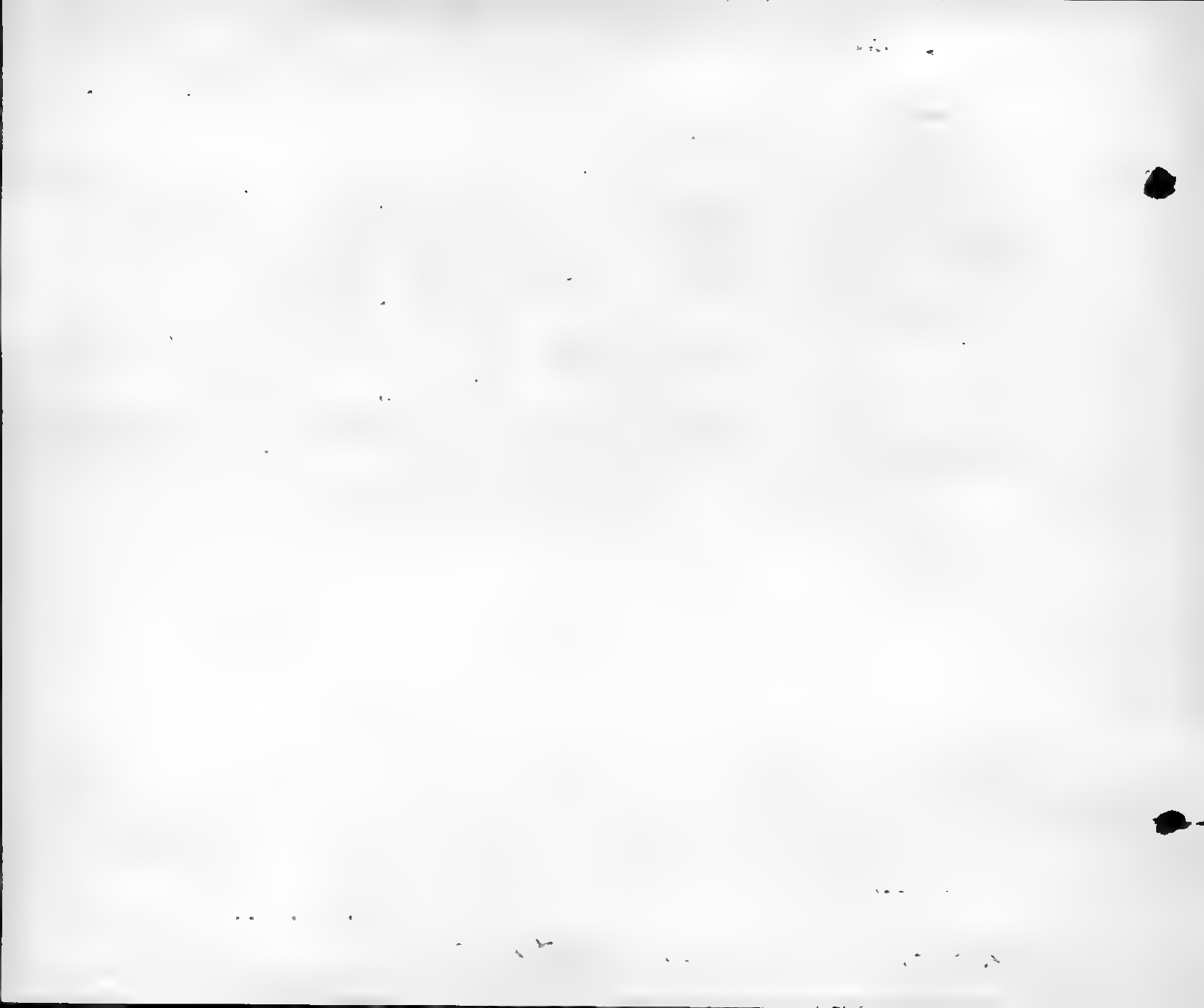
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

939

60952

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>23 days</u>				d. STREET ADDRESS <u>3701 - Conn. Ave. N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Glady's Vivian Singleton</u>				4. DATE OF DEATH Month Day Year <u>Jan. 20 1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/12/25</u>	
9. AGE (In years last birthday) <u>35</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Import & Export</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Robt. B. Singleton</u>				14. MOTHER'S MAIDEN NAME <u>Glady's Atkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>no</u>				16. SOCIAL SECURITY NO <u>no</u>		17. INFORMANT <u>Glady's Atkins Singleton</u> Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALIGNANT MELANOMA</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month Day Year Hour a m p m _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>JAN 20</u> , 19 <u>61</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>JAN 20</u> , 19 <u>61</u> , and that death occurred at <u>11:50</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>DeWitt E. DeLawter</u>				22b. DATE SIGNED <u>JAN 20 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>DEWITT E. DELAWTER</u>				22d. ADDRESS <u>5025 ABERDEEN RD, Bethesda 14, MD</u>			
23a. BURIAL OR CREMATION REMOVAL (Specify)		23b. DATE THEREOF <u>1/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				25a. REC'D BY REGISTRAR <u>2901-14th St N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	
				DATE <u>JAN 23 '61</u>		Wash, D.C.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66953

1. PLACE OF DEATH
COUNTY Montgomery, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 5 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission)
STATE District of Columbia b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 1725-17th St., N.W.

3. NAME OF DECEASED (Type or print) Ella Virginia Souder
First Middle Last
4. DATE OF DEATH January 9, 1961
Month Day Year
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH September 1, 1885
9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA American

13. FATHER'S NAME Thomas Wyn Kopp
14. MOTHER'S MAIDEN NAME Sally Hammerly
15. WAS DECEASED EVER IN U.S. ARMED FORCES? None
16. SOCIAL SECURITY NO. 579-30-0252
17. INFORMANT Washington Sanitarium & Hospital Records
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
900.00 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Fracture of skull
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 1 1/2 days

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

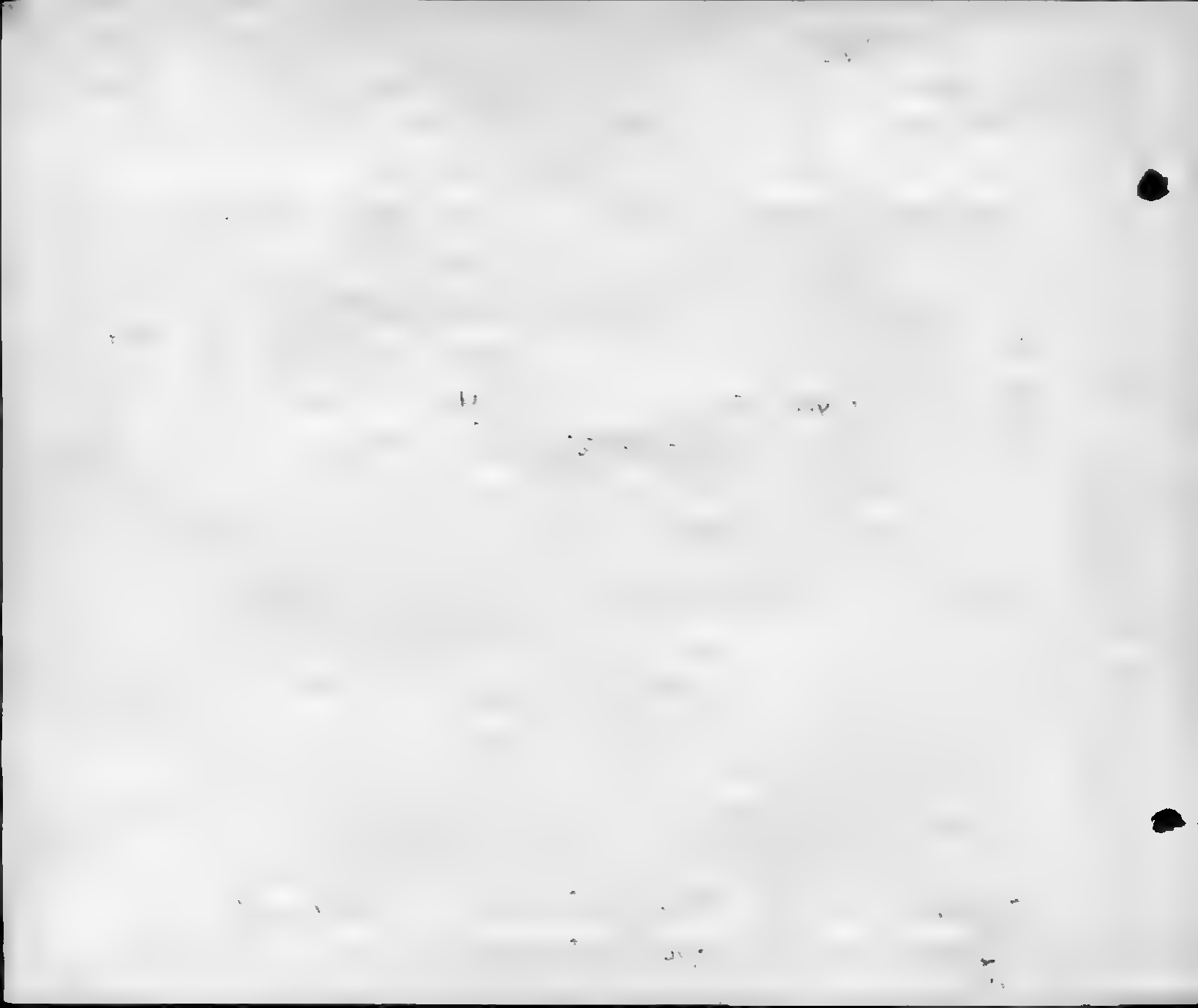
20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH. Fell backward down stairs at sister's home
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 8:53 p.m. 1-8 1961
20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8100 Hammond Ave. Takoma Park Montg Md
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschant
EXAMINER'S NAME (Type) FRANK J. Broschant
M.D.
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) 1-9-61

22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION
22b. DATE THEREOF 1-12-1961
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY
22d. LOCATION (City, town, or country) (State) SUITLAND, MD.

23. FUNERAL DIRECTOR Joseph Gaudin's Sons, Inc. 1756 Pa. Ave. N.W. Wash. D.C.
ADDRESS
24a. REC'D BY REGISTRAR DATE JAN 12 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
941 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>							
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>				c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8733 Carroll Ave</u>				d. STREET ADDRESS <u>8733 Carroll Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mae Sarah Steele</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>30</u> Year <u>1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-1879</u>		9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trained nurse, retired</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown Eldridge</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Robt. E Moore (son)</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a) <u> </u> b) <u> </u> c) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>QVA, 2 yrs ago</u>											
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)				(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1-30-61</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-3-1961</u>				22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Mason Hyattsville, Maryland</u>			
23. FUNERAL DIRECTOR <u>W. M. Chambers Co. - Pikesville Md.</u>				24a. REC'D BY REG. STRAR DATE <u>FEB 2 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



942

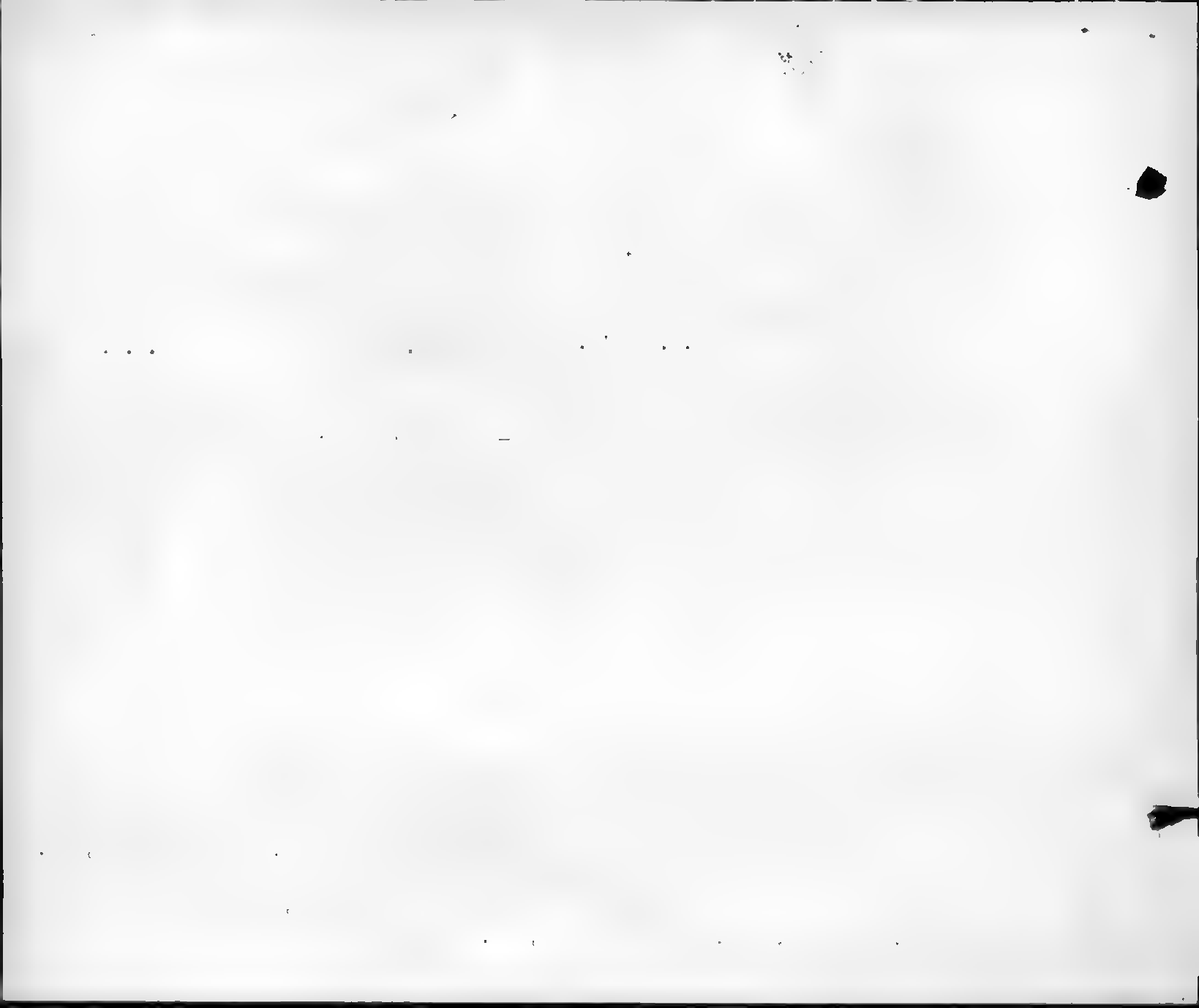
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00935

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN 1b 37 hrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 19914 Indi an Spring L ane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HOWA RD Middle R. Last STOKER				4. DATE OF DEATH Month Jan. Day 16 Year 19 61			
5. SEX Male	6. COLOR OR RACE Wh ite	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/19/84	9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months Days Hours M'n	IF UNDER 24 HRS M'n
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U/S.A.	
13. FATHER'S NAME Jackson Stoker STOCKER				14. MOTHER'S MAIDEN NAME Mary unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no yes		16. SOCIAL SECURITY NO. (If not give year or date of service) WW #1		17. INFORMANT Wife - Jennifer Address same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Decompensation 41' x DUE TO Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Rheumatic fever (old) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Enter selection							INTERVAL BETWEEN ONSET AND DEATH 1-2 "
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 54 to 16 Jan 19 61 , that (I) (we) last saw the deceased alive on 15 Jan 19 61 , and that death occurred at 10 PM , from the causes and on the date stated above							
22a. SIGNATURE William D. And M.D.				22b. DATE SIGNED 16 Jan 61		22c. PHYSICIAN'S NAME (Type) William D. And	
22d. ADDRESS 9006 Colesville Rd., Silver Spring, Md.							
23a. BURIAL CREMATION, REMOVA (Specify) BURIAL		23b. DATE THEREOF 1/20/61		23c. NAME OF CEMETERY OR CREMATORY CHARLES EVANS CEMETERY		23d. LOCATION (City, town, or county) (State) READING, PENNSYLVANIA	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. POMPHELY, INC. SILVER SPRING, MD. Signe R. Jirka				25a. REC'D BY REGISTRAR DATE JAN 25 '61		25b. REGISTRAR'S SIGNATURE Caroline S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

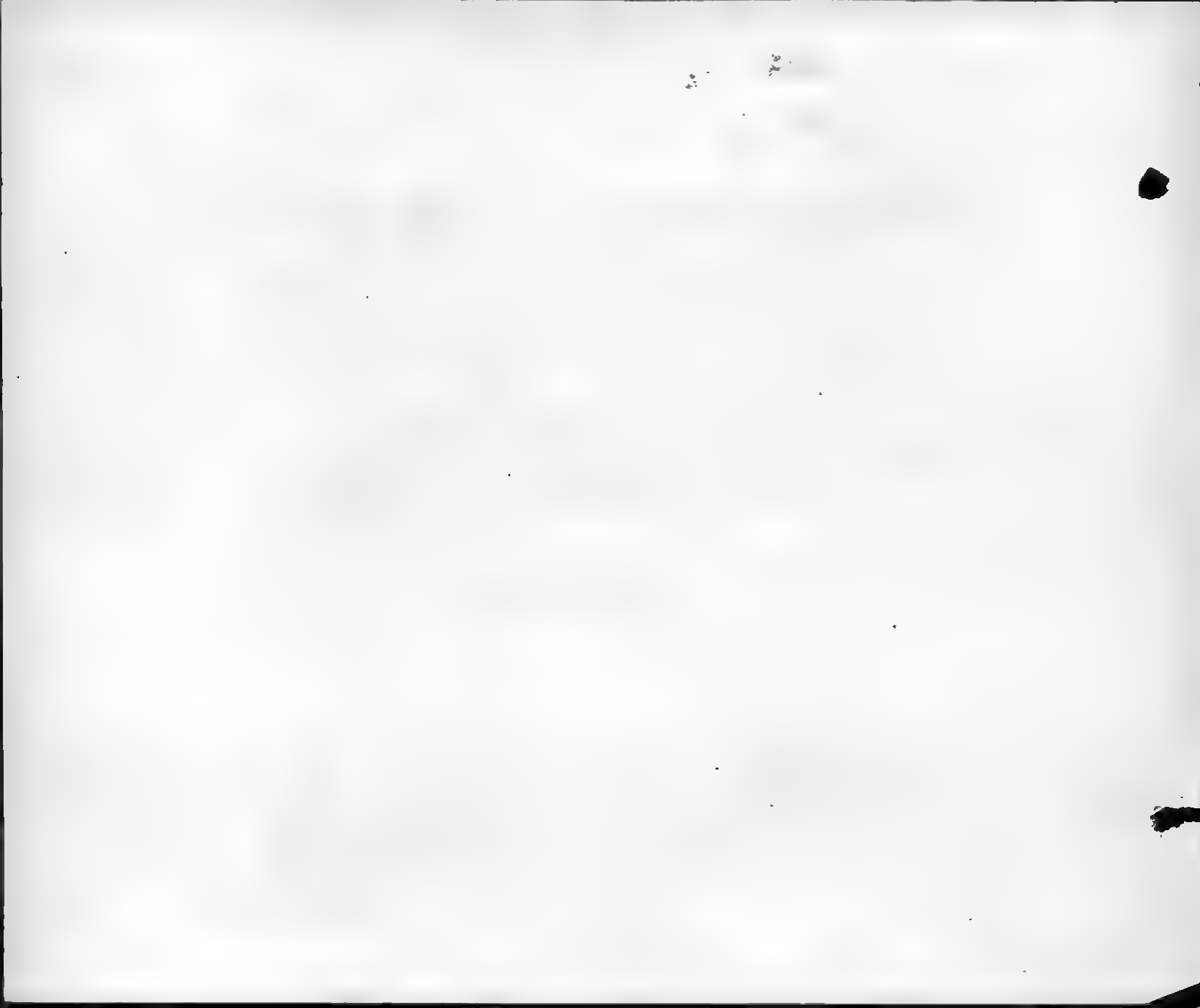
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.



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943
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00956

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>11 mo.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		d. STREET ADDRESS <i>911 R. Henthouse St. N. W.</i>	
3. NAME OF DECEASED (Type or print) <i>Lucy D. Stoner</i>		4. DATE OF DEATH <i>Jan. 27 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 19, 1894</i>
9. AGE (In years last birthday) <i>66 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>File Clerk (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov.</i>	11. BIRTHPLACE (State or foreign country) <i>Alexandria, Va.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth De Vaughn</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT <i>Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Healed pulmonary tb.; Rheumatoid Arthritis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While of work Not while at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>2-22-1960</i> to <i>2-27-1961</i> , that (I) (we) lost saw the deceased alive on <i>2-26-1961</i> , and that death occurred at <i>7:00 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>C. H. Higdon</i>		22b. DATE SIGNED <i>1/27/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>C. H. Higdon</i>		22d. ADDRESS <i>Sandy Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>1-28-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	23d. LOCATION (City, town, or county) (State) <i>Scutland Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros.</i>		25a. REC'D BY REGISTRAR <i>WASH 20</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>		DATE <i>JAN 30 '61</i>	



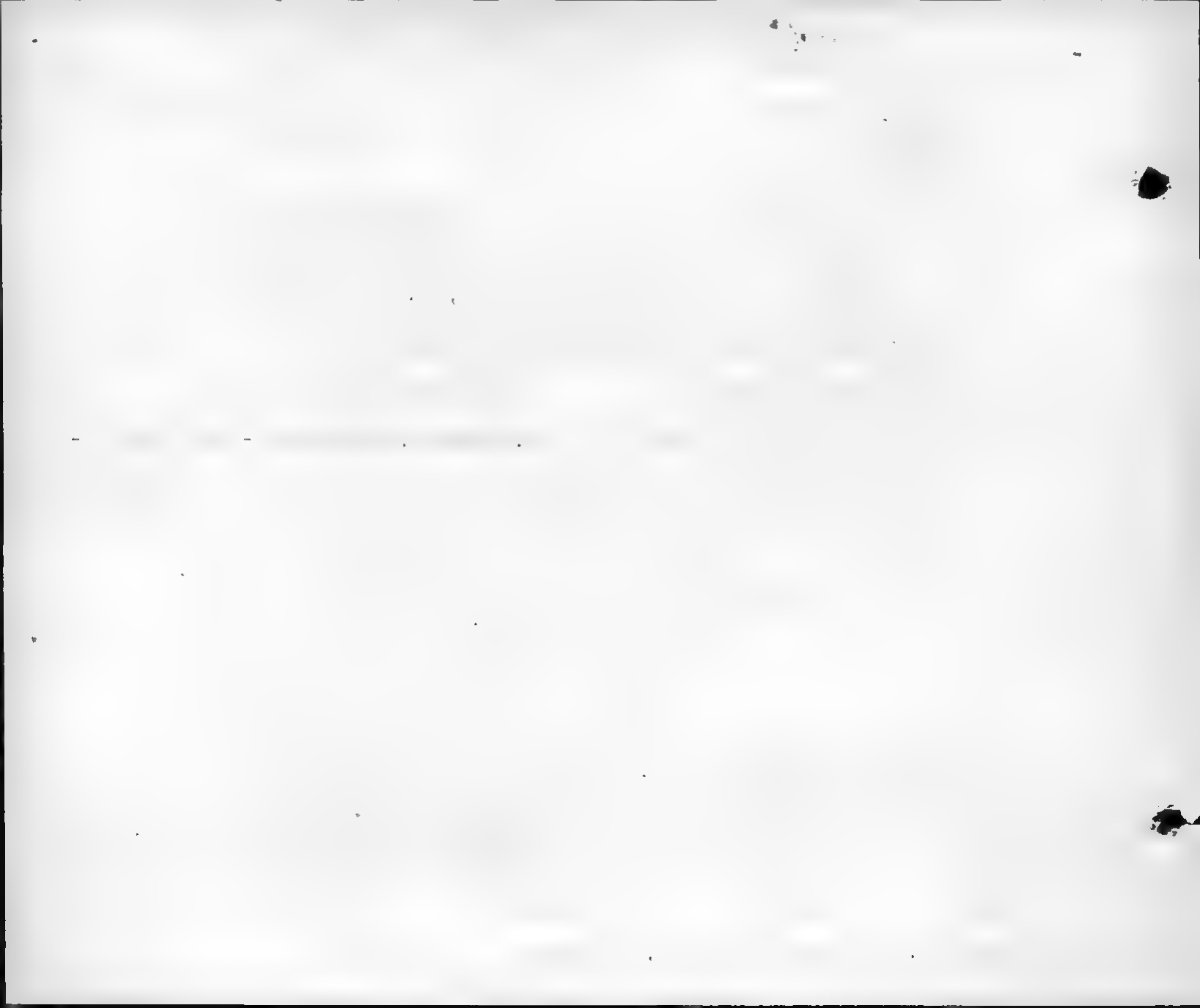
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The page please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66957

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 42 d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph Waldo Strawbridge		4. DATE OF DEATH JAN. 26, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR 6 Months 27 Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Principal-high school		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Neilson Strawbridge		14. MOTHER'S MAIDEN NAME Elizabeth Duncan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Jennie R. Strawbridge-Same Item #2-Wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA, 420.0 DUE TO (b) MYOCARDIAL DECOMPENSATION 10 DAYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ARTERIO-SCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 48 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) BRONCHIAL ASTHMA (2) CARCINOMA - RT. LUNG		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 1-26 , 1961, that (I) (last) saw the deceased alive on 1-25 , 1961, and that death occurred on 1-26 at 12:35 PM from the causes and on the date stated above.			
22a. SIGNATURE James W. Lowe M.D.		22b. DATE SIGNED 1-26-61	
22c. PHYSICIAN'S NAME (Type) JAMES W. LOWE		22d. ADDRESS 6601 - GREENTREE RD BETH	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/28/1961	
23c. NAME OF CEMETERY OR CREMATORY Center Cemetery		23d. LOCATION (City, town, or county) (State) Stewartstown Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		25a. REC'D BY REGISTRAR JAN 30 '61	
25b. REGISTRAR'S SIGNATURE C. W. S. Thomas			



1995a

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution. Residence before admission) b. COUNTY <u>Montgomery</u> MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2813 Hardy Avenue</u>		d. STREET ADDRESS <u>12813. Hardy Ave</u>	
3. NAME OF DECEASED (Type or print) <u>ELWOOD EUGENE STUMP</u>		4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July.5.1910</u>
9. AGE (In years last birthday) <u>50</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Samuel Stump</u>		14. MOTHER'S MAIDEN NAME <u>Ida (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Marguerite.E. Stump</u>		Address <u>2813.Hardy ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO (b) <u>Progressive paralysis of respiratory muscles</u> DUE TO (c) <u>Atrophic lateral sclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 4</u> , 19 <u>61</u> , to <u>Jan 12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>61</u> , and that death occurred at <u>8:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eino Magi</u>		DATE SIGNED <u>1/12/61</u>	
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		ADDRESS (Street, city or town, state) <u>918 University Blvd. E. Silver Spring, Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1.16.1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>300.4th.st N E.Wash.</u>	
24a. REC'D BY REGISTRAR <u>JAN 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>	

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. CE939

946

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>		d. STREET ADDRESS <u>5301-N.H. AVE N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>MAX</u> Middle <u>SYKES</u> Last <u>SYKES</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERMAN SYKES</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>577-055463 A</u>	
17. INFORMANT <u>ELLY SYKES</u>		Address <u>APT-109 5301-N.H. AVE N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNDET.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>TUMOR OF URINARY BLADDER, NON-FUNCTIONING LT. KIDNEY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>55</u> , to <u>JAN 23</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>JAN. 22</u> , 19 <u>61</u> , and that death occurred at <u>2:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B.P. Lafsky</u> M.D.		ADDRESS (Street, city or town, state) <u>5301-TANGLEWOOD DR. BETHESDA</u>	
PHYSICIAN'S NAME (Type) <u>BENJAMIN P. LAESKY</u>		DATE SIGNED <u>1/23/61</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/27/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ADAS ISRAEL TEM</u>	22d. LOCATION (City, town, or county) (State) <u>DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bolaterg Funeral Home</u>		24a. REC'D BY REGISTRAR <u>4217-9th Xee</u>	
24b. REGISTRAR'S SIGNATURE <u>John S. Hume</u>		DATE <u>JAN 25 '61</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

00941

947

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAVAREST NURSING HOME</u>				d. STREET ADDRESS <u>1013 Osage St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PEBBLE E. TANNER</u>				4. DATE OF DEATH Month Day Year <u>Jan 28 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 20 1897</u>	
9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk U.S. Gen Treasury</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Harry Burroughs</u>				14. MOTHER'S MAIDEN NAME <u>Edith Magruder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Eugene Tanner</u>			
17. INFORMANT <u>Eugene Tanner</u>				Address <u>8901 Walden Rd Silver Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>174X</u> IMMEDIATE CAUSE (a) <u>Adenocarcinoma of uterus with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ DUE TO _____ DUE TO _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1852</u> to <u>28 Jan 1961</u> that I lost saw the deceased alive on <u>27 Jan 1961</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William D. Luff</u> M.D.				ADDRESS (Street, city or town, state) <u>9016 Lakeside Rd, Silver Spring Md</u>			
DATE SIGNED <u>1/28/61</u>							
PHYSICIAN'S NAME (Type) <u>Silver Spring Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>				ADDRESS <u>4812 St. Andrew Ave</u>		24a. REC'D BY REGISTRAR <u>Feb 6 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

10

1
MONTGOMERY CO. MEDICAL EXAMINER NOTIFIED AND RELEASED AS MEDICAL OFFICER
was in attendance in ambulance at time of death.

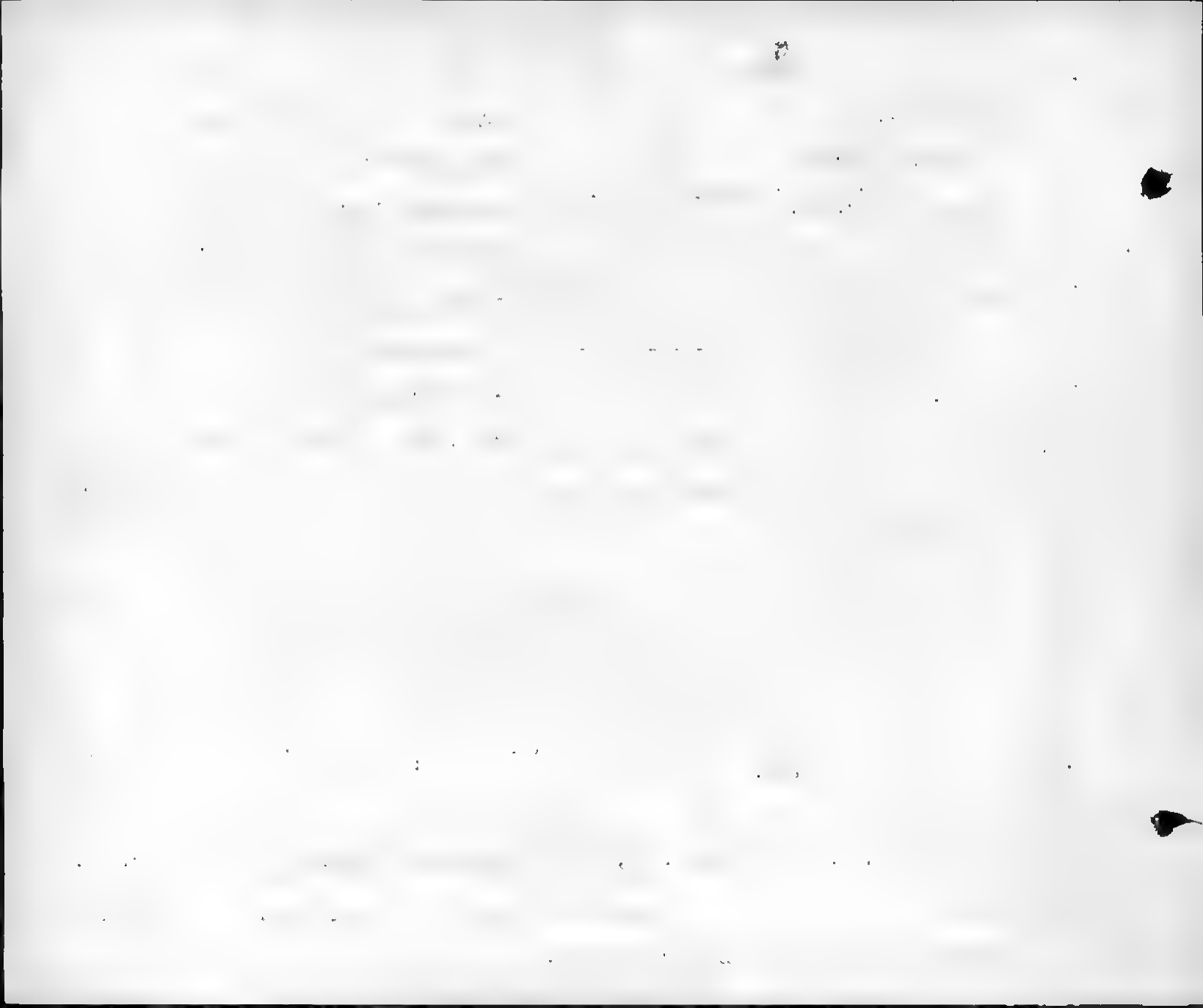
1-10-61
-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00941

948- Birth Cert. et
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS 36 Salamau Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Linda Middle Gay Last TATON		4. DATE OF DEATH Month January Day 12 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-59
9. AGE (In years last birthday) 1 yrs		10. IF UNDER 1 YEAR Months 1 Days 18 Hours 2	11. IF UNDER 24 HRS Hours 18 Min 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland, St. M. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl J. TATON		14. MOTHER'S MAIDEN NAME Betty Marilyn COLE	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT (F) Carl J. Taton, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis, acute, bacterial 340.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Culture positive for H. Influenza		INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) XXXXXX attended the deceased from Jan. 12 1961 to Jan. 12 1961 that (I) was last saw the deceased alive on Jan. 12 1961 , and that death occurred at 11:50AM M, from the causes and on the date stated above.			
22a. SIGNATURE D. G. Anderson		22b. ADDRESS Station Hospital, Patuxent River, Md.	
22c. PHYSICIAN'S NAME (Type) D. G. ANDERSON, LT, MC, USN		22d. ADDRESS Station Hospital, Patuxent River, Md.	
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Mattingly Funeral Home, Leonardtown, Md.		25a. REC'D BY REGISTRAR DATE JAN 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE 1-12-61	



949

CERTIFICATE OF DEATH

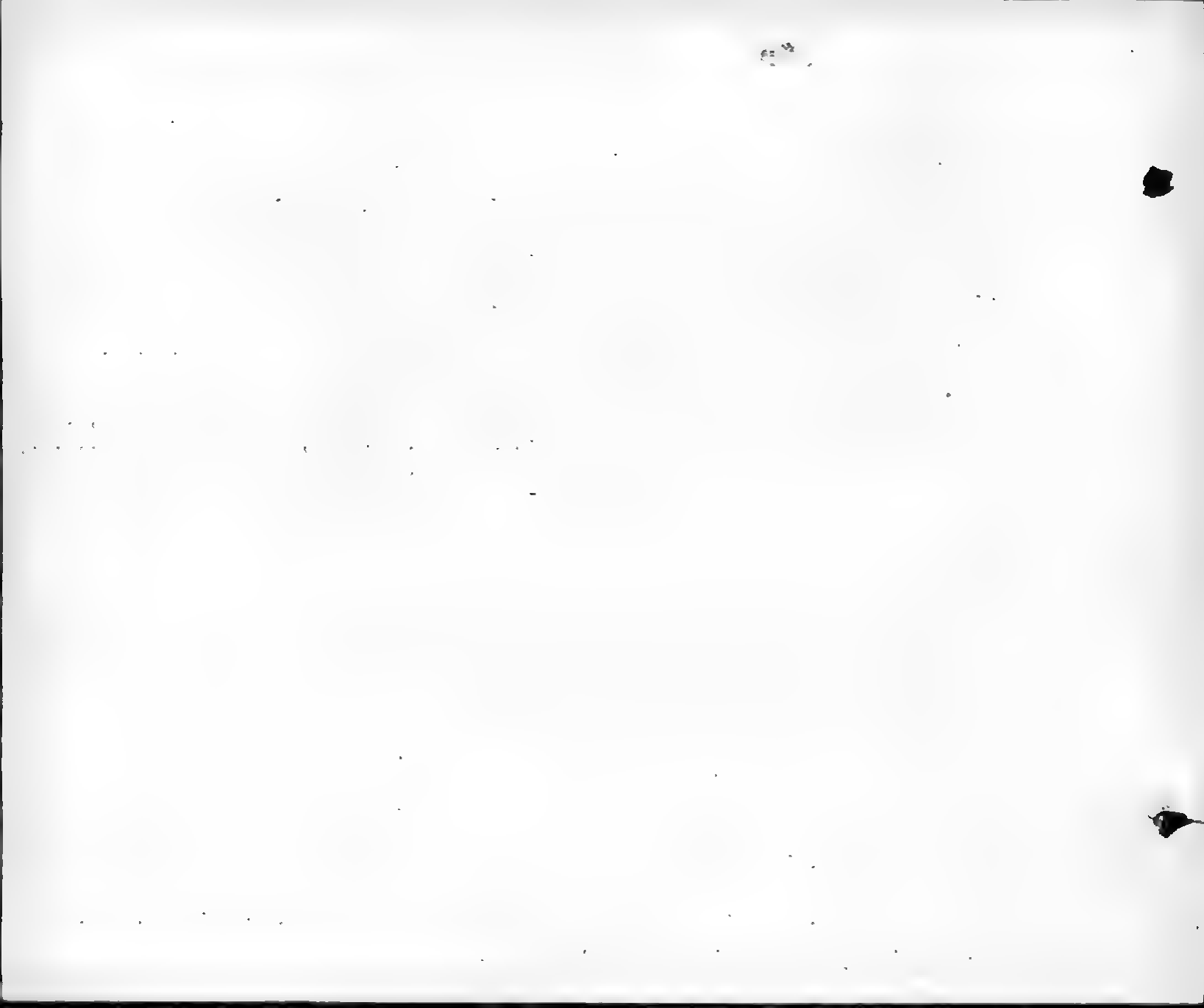
Reg. Dist. No.

00942

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY WARWICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ASHTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORFOLK	
c. LENGTH OF STAY IN lb 3 MONTHS		d. STREET ADDRESS 9606 - 16th ST., EAST OCEAN VIEW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BELMONT NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROSEMARY SUSAN UTZ		4. DATE OF DEATH Month Day Year JANUARY 8 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 3, 1885
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN ANDREWS		14. MOTHER'S MAIDEN NAME UNKNOWN RODMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MRS. HELEN E. JOHNSON, 7414 GEORGIA AVE., N.W.,		Address WASHINGTON, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 18 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 11 , 19 60 to JAN 8 , 19 61 , that I last saw the deceased alive on 1-3 , 19 61 , and that death occurred at 12:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Roy B. Parsons, Jr.		ADDRESS (Street, city or town, state) 15544 Columbia Rd Burtonsville Md	
PHYSICIAN'S NAME (Type) ROY B. PARSONS, JR.		DATE SIGNED 1-5-61	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 11, 1961	22c. NAME OF CEMETERY OR CREMATORY FOREST LAWN CEMETERY	22d. LOCATION (City, town, or county) (State) NORFOLK, WARWICK CO., VA.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.,		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE JAN 11 '61		24b. REGISTRAR'S SIGNATURE C. H. S. FINE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
950 **CERTIFICATE OF DEATH**

60943

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 63 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2 USUAL RESIDENCE (Where deceased lived If institutional - Residence before admission) a. STATE Florida b. COUNTY St. Petersburg c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 5327 5th Ave. N d. STREET ADDRESS 5327 5th Ave. N e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Henry Clifford VAUGHN				4. DATE OF DEATH Month Day Year January 10 1966			
5. SEX Male		6 COLOR OR RACE Caucasian		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 5-21-91	
9 AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Giles VAUGHN				14. MOTHER'S MAIDEN NAME Katherine KNOX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWI & II				16 SOCIAL SECURITY NO None		17 INFORMANT (W) Mrs. Blanche Vaughn, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cerebral tumor 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Branchiogenic carcinoma DUE TO (c) > 7 mos.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nov. 8 1960 to Jan. 10 1961	
20f. (City or town) Nov. 8 1960 to Jan. 10 1961				(County) (State)			
21. I certify that (1) (this hospital) attended the deceased from Nov. 8 1960 to Jan. 10 1961 , that (1) (we) last saw the deceased alive on Jan. 10 1961 , and that death occurred at 9:55 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>F. M. Highly, Jr.</i>				22b. DATE 1-11-61			
22c. PHYSICIAN'S NAME (Type) F. M. HIGHLY, JR., LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i> Lee Funeral Home, 4th & Mass. Aves., NW, WashDC				25a. REC'D BY REGISTRAR JAN 13 61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

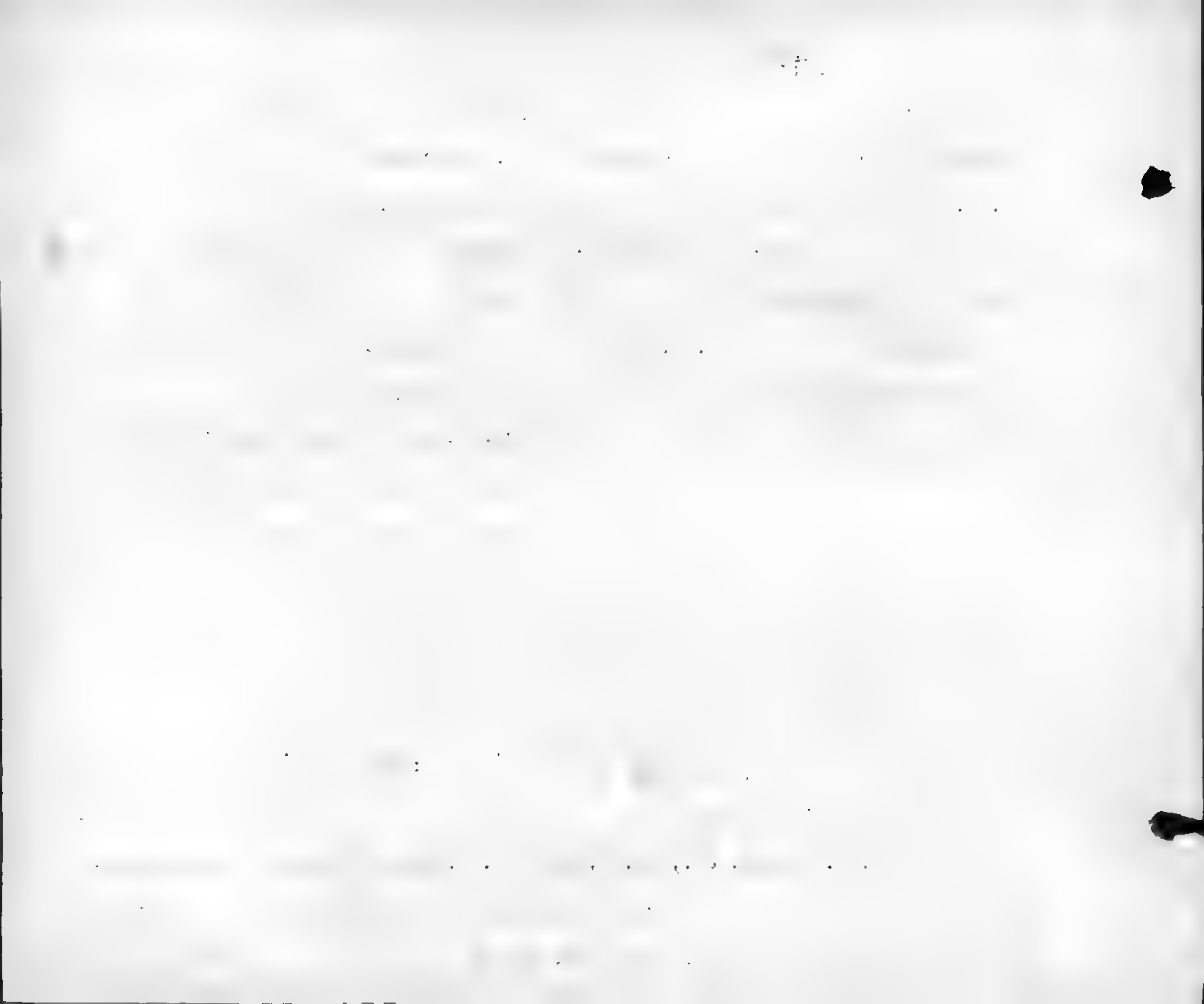
MEDICAL CERTIFICATION

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

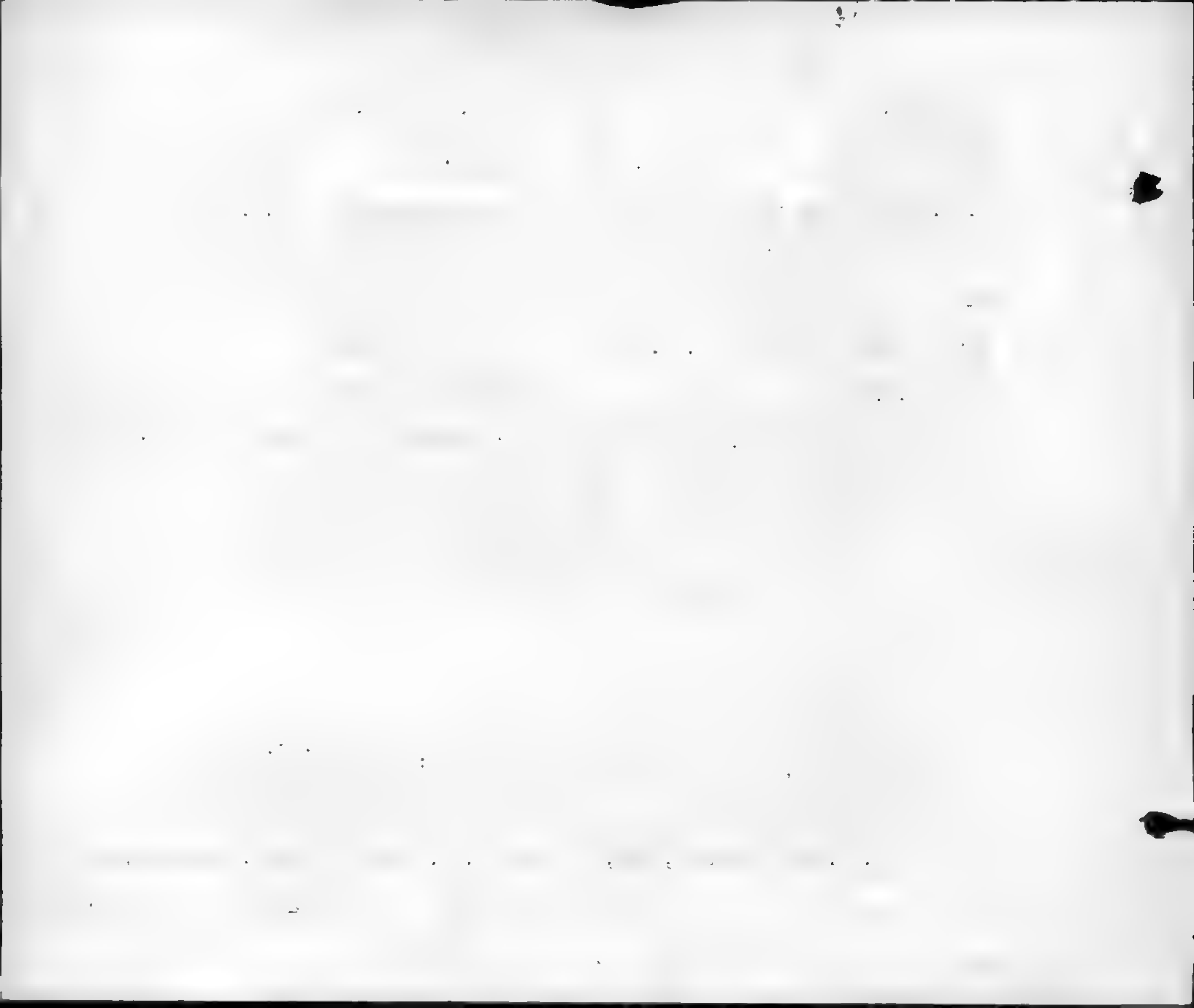
951

CERTIFICATE OF DEATH

66944

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1400 Fairmount St., N.W. d. STREET ADDRESS 1400 Fairmount St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Calvin VIA				4. DATE OF DEATH Month Day Year January 25 19 61			
5 SEX Male		6 COLOR OR RACE Caucasian		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 3-7-29	
9. AGE (In years last birthday) 31 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner (Retired)				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11 BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME James W. VIA				14. MOTHER'S MAIDEN NAME Mary E. LAFORN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII & Korean				16. SOCIAL SECURITY NO 235 36 9877		17 INFORMANT (W) Mrs. Mary M. Via, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RHEUMATIC HEART DISEASE INACTIVE ; (MITRAL STENOSIS AND INSUFFICIENCY ; AORTIC INSUFFICIENCY) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) STENOSIS AND INSUFFICIENCY ; AORTIC INSUFFICIENCY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (X) (this hospital) attended the deceased from Jan. 18 1961 to Jan. 25 1961 , that (H) (we) last saw the deceased alive on Jan. 25 19 61 , and that death occurred at 2:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>J. E. McClenathan</i>				22b. ADDRESS J. E. MC CLENATHAN, CDR, MC, USN U. S. Naval Hospital, Bethesda, Md.		22c. PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 1-27-61		23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		23d. LOCATION (City, town, or county) (State) Princeton West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Chevy Chase Funeral Home, 5103 Wisc. Ave. NW, Wash DC				25a. REC'D BY REGISTRAR JAN 30 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hearn</i>	

TO HOSPITAL ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

14

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VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) SILVER SPRING						c. LENGTH OF STAY IN 1b 12 years					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10,218 COLESVILLE ROAD						e. STREET ADDRESS 10,218 COLESVILLE ROAD					
3. NAME OF DECEASED (Type or print) JOSEPHINE ESTHER VIPOND						4. DATE OF DEATH JAN. 31 1961					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/10/78		9. AGE (In years (If UNDER 1 YEAR last birthday) 82 yrs. Months Days Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home				11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Edge				14. MOTHER'S MAIDEN NAME Lucinda Gilbert							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. yes		17. INFORMANT Mr. Louis M. Vipond, 10,218 Colesville Rd. Silver Spring, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
SIGNATURE Frank J. Broschart M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) FRANK J. BROSCART						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED 1-31-61					
22a. BURIAL, CREMATION, TRANS., & REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2/4/61		22c. NAME OF CEMETERY OR CREMATORY Scales Mound Citizens Cemetery		22d. LOCATION (City, town, or country) (Site a) Scales Mound, Illinois			
23. FUNERAL DIRECTOR E. PUMPHREY, INC. Raymond A. Ziska						ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

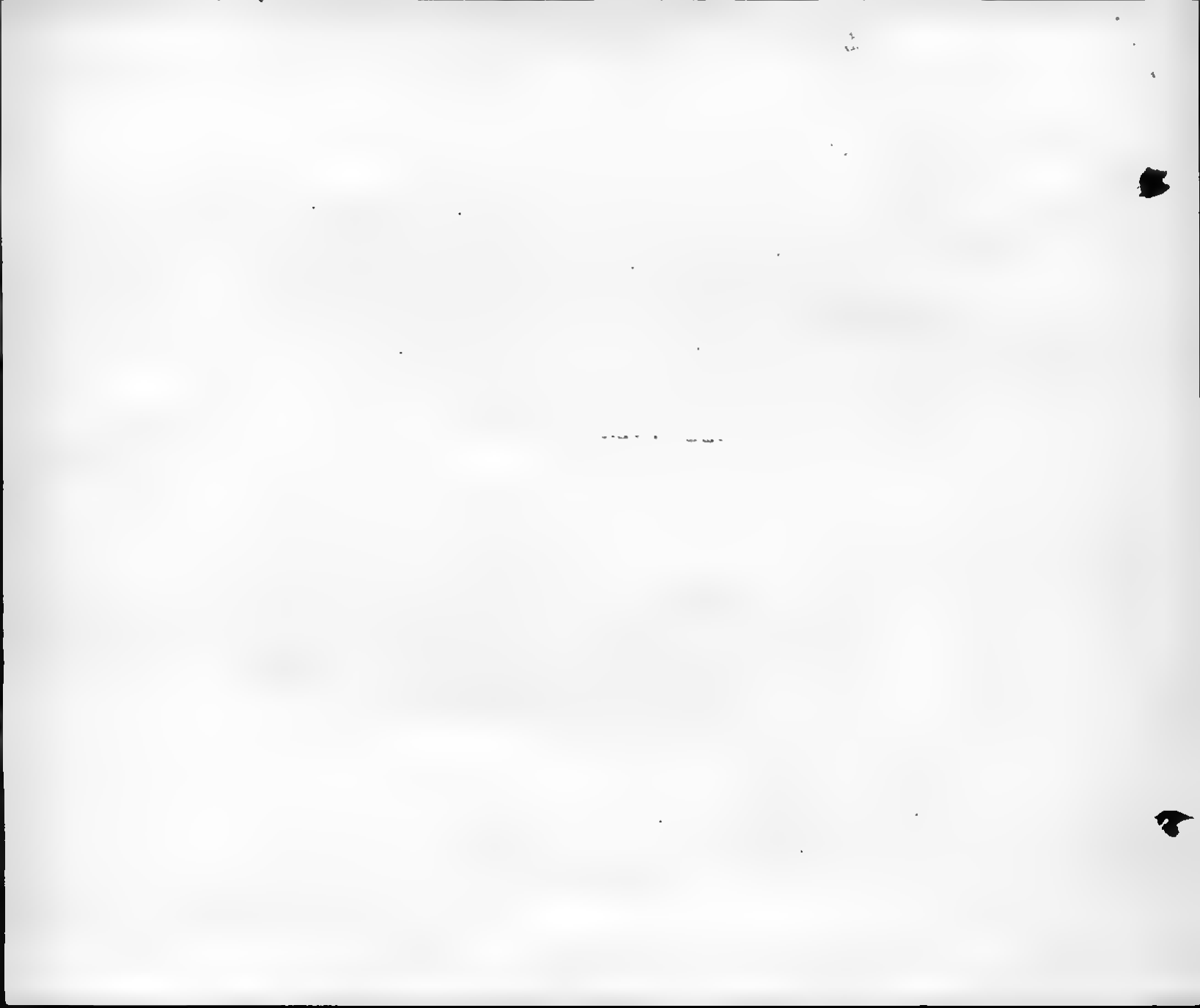


1. **THE HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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953
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60946

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Bertha Ella Wade</i>		4. DATE OF DEATH Month Day Year <i>Jan. 16 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/5/85</i>
9. AGE (In years last birthday) <i>75</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child's nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>retired</i>	
11. BIRTHPLACE (State or foreign country) <i>France</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Augustus Rolle H</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>566-42-6108</i>	
17. INFORMANT <i>Elaine R. Wade</i>		Address <i>14224 Hi-Wood Dr.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral infarction</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <i>cerebral thrombosis</i> DUE TO (c) <i>Cerebral Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs.</i> <i>8 hrs.</i> <i>Protracted</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/1/1960</i> to <i>1/16/1961</i> , that (I) (we) last saw the deceased alive on <i>1/16/1961</i> , and that death occurred at <i>6:00</i> M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Stephen J. Friedman</i> M.D.		22b. DATE SIGNED <i>1/16/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>N. J. ...</i>		22d. ADDRESS <i>Rockville, Maryland</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Interment</i>		23b. DATE THEREOF <i>1/17/61</i>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <i>Larox, Massachusetts</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler</i> ADDRESS <i>Rockville, Maryland</i>		25a. REC'D BY REGISTRAR <i>DATE JAN 19 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

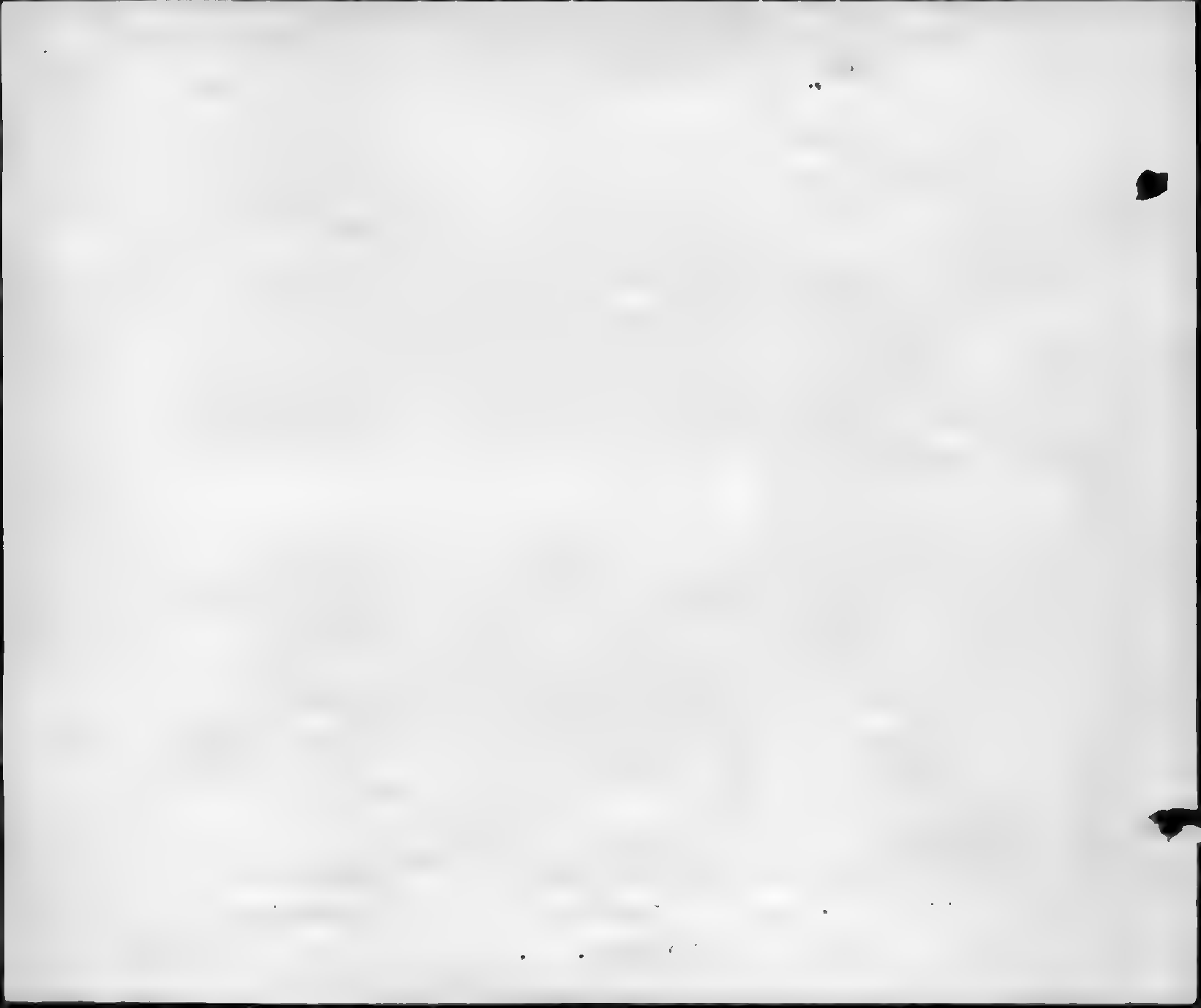
954 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66957

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>	
c. LENGTH OF STAY IN 1b <u>20 yr</u>		d. STREET ADDRESS <u>Md R-121</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Md R-121</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bradley</u> Middle <u>Warfield</u> Last <u>Warfield</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-1908</u>
9. AGE (in years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>52</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Bradley W. Warfield</u>		14. MOTHER'S MAIDEN NAME <u>Georgia King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <u>73 111 1111</u>	
17. INFORMANT <u>Wesley Warfield</u>		Address <u>73 Hammond Dr Clarksburg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>same as above</u> (c) <u>same as above</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>same as above</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>0</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-4-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 6 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		22d. LOCATION (City, town, or country) (State) <u>Laytonsville Md</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>		ADDRESS <u>Laytonsville. Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kirsch</u>	

THIS MEDICAL EXAMINER'S CERTIFICATE should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

955

00948

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN Bldg. <u>7 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1334 Jexxerson st. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bella Effie Watkins</u>		4. DATE OF DEATH Last <u>1</u> Month <u>12</u> Year <u>1961</u>	
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-17-79</u> 9. AGE (In years last birthday) <u>81</u> 10. IF UNDER 1 YEAR Months _____ Days _____ 11. IF UNDER 24 HRS. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Parker</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Coghill</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Hosp. Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Arteriosclerosis</u> (a), stating the underlying cause last. (c) _____		19. INTERVAL BETWEEN ONSET AND DEATH <u>51 Hours</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Cerebral Vascular Accident - 5-20-60</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
21c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		21f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>5-20</u> <u>1960</u> to <u>1-12</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>1-12</u> <u>1961</u> and that death occurred at <u>2:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>1-12-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>		22d. ADDRESS <u>7425 Aspen Court Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial</u> <u>1/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	
23d. LOCATION (City, town or county) <u>Leesburg, Virginia</u>		23e. (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		24a. ADDRESS <u>2901-17th St NW</u>	
24b. REC'D BY REGISTRAR <u>DATE JAN 16 '61</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12. 1. 1. 1. 1. 1.

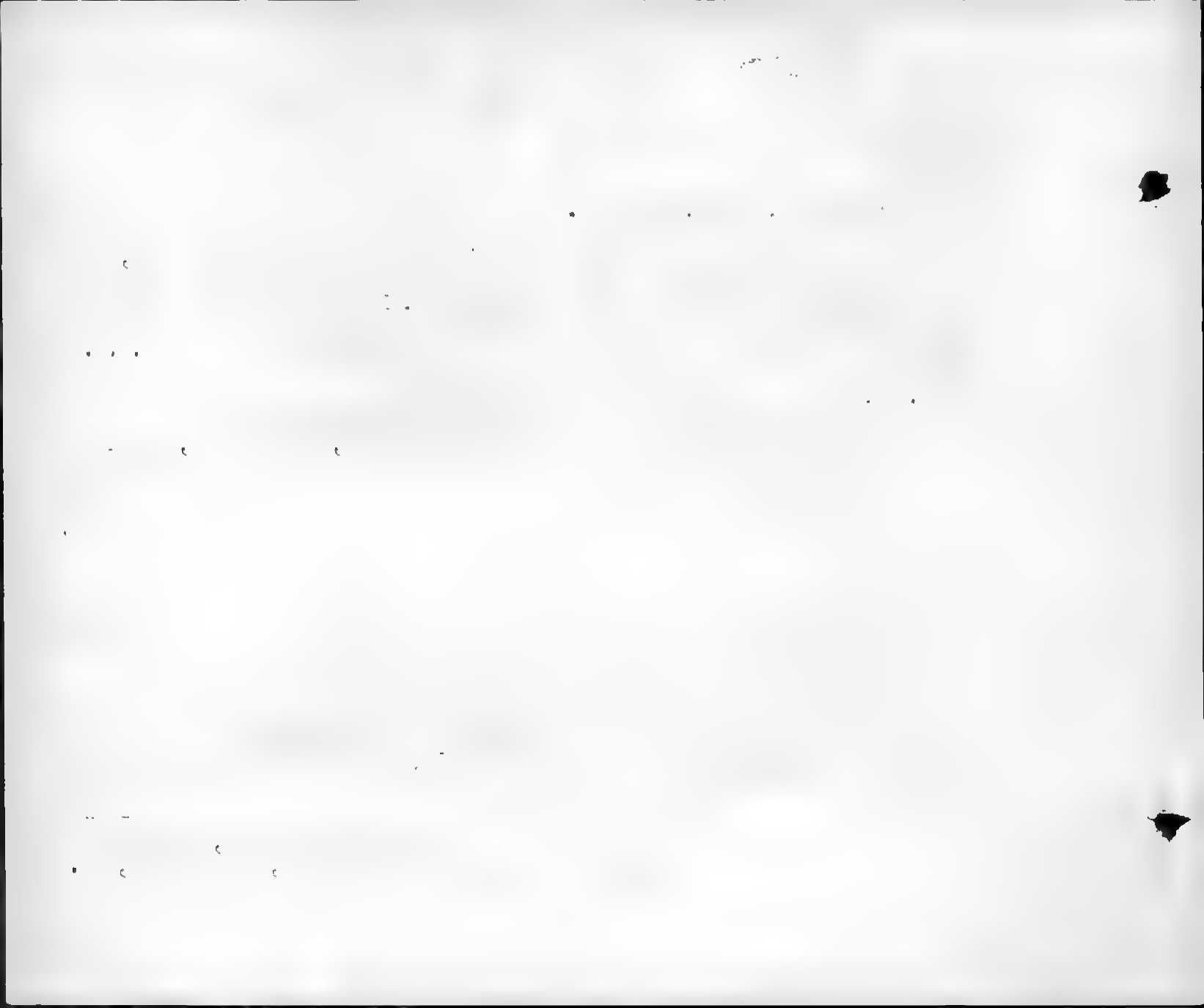
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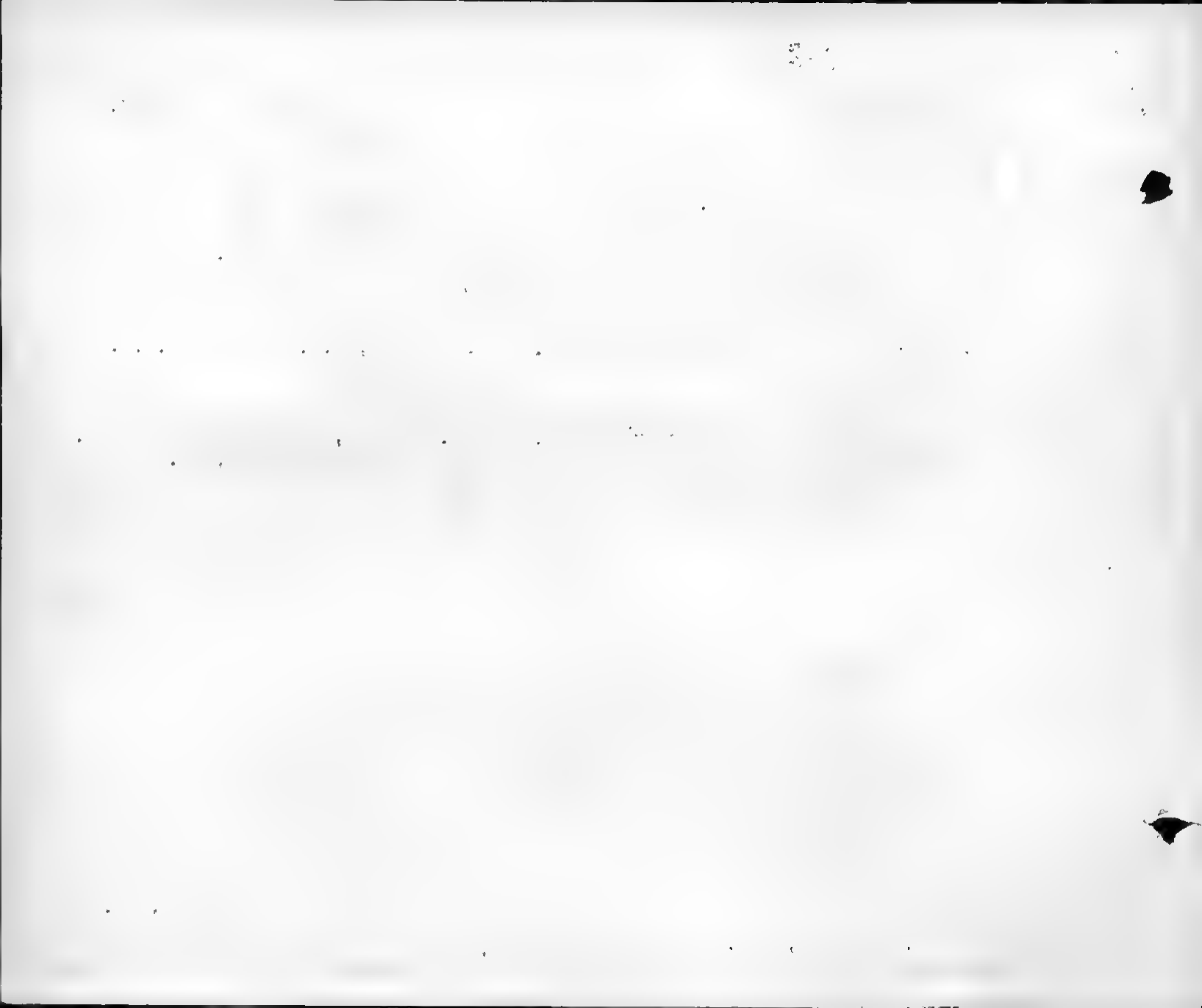
956

60921

1. PLACE OF DEATH a. COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. COUNTY Kentucky						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 14 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Louisville						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.	d. STREET ADDRESS 648 Eastlawn	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Mark	Middle Wayne	Last Weber	4. DATE OF DEATH Month January	Day 11,	Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 24, 1948	9. AGE (In years last birthday) 12 yrs	IF UNDER 1 YEAR Months 12	IF UNDER 24 MRS Days 11	Hours 11	Min 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Colorado	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Wayne E. Weber	14. MOTHER'S MAIDEN NAME Vivian Shea							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT The Medical Record	Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Widespread Carcinomatosis DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 1 day 9 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from December 28, 1960 to January 11, 1961 , that (I) (we) last saw the deceased alive on January 11, 1961 , and that death occurred on January 11, 1961 , from the causes and on the date stated above								
22a. SIGNATURE Robert B. Scoggins	M.D. ROBERT B. SCOGGINS, M.D.	22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	22c. DATE SIGNED 1-11-61					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/12/1961	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City, town, or county) Louisville Ky.					
24. FUNERAL DIRECTOR'S SIGNATURE By Song & Funeral Home	ADDRESS WASH. D.C.	25a. REC'D BY REGISTRAR DATE 1-13-61	25b. REGISTRAR'S SIGNATURE William S. Thomas					



1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 ROCKVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				d. STREET ADDRESS 14308 INDEPENDENCE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle WESLEY Last WHITNEY				4. DATE OF DEATH Month JAN. Day 17 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/15	
9. AGE (In years last birthday) 45 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Co-owner				10b. KIND OF BUSINESS OR INDUSTRY Wheaton Glass Co.		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Wesley Whitney				14. MOTHER'S MAIDEN NAME Annie Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 577-03-1155			
17. ADDRESS Rockville, Md.				18. INTERVAL BETWEEN ONSET AND DEATH 4 days			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 581.1 IMMEDIATE CAUSE (a) Blood poisoning due to ulcer DUE TO (b) Cirrhosis, alcoholic DUE TO (c) Alcoholism				20. INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
23a. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 1961 p. m.				23b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				23d. (City or town) (County) (State)			
24. I certify that I attended the deceased from 1/10 , 19 61 , to 1/17 , 19 61 , that I last saw the deceased alive on 1/17 , 19 61 , and that death occurred at M. , from the causes and on the date stated above.				25. ADDRESS (Street, city or town, state) DATE SIGNED			
26. ACTUAL SIGNATURE Donald Nelson				27. M.D. 16620 York Road Silver Spring, Md.			
28. PHYSICIAN'S NAME (Type) DONALD NELSON							
29a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				29b. DATE THEREOF 1/21/61			
29c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY				29d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.			
30. FUNERAL DIRECTOR'S SIGNATURE Harmon G. Gaska				31. ADDRESS SILVER SPRING, MD.			
32. REC'D BY REGISTRAR JAN 25 '61				33. REGISTRAR'S SIGNATURE Carlton S. Kline			



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

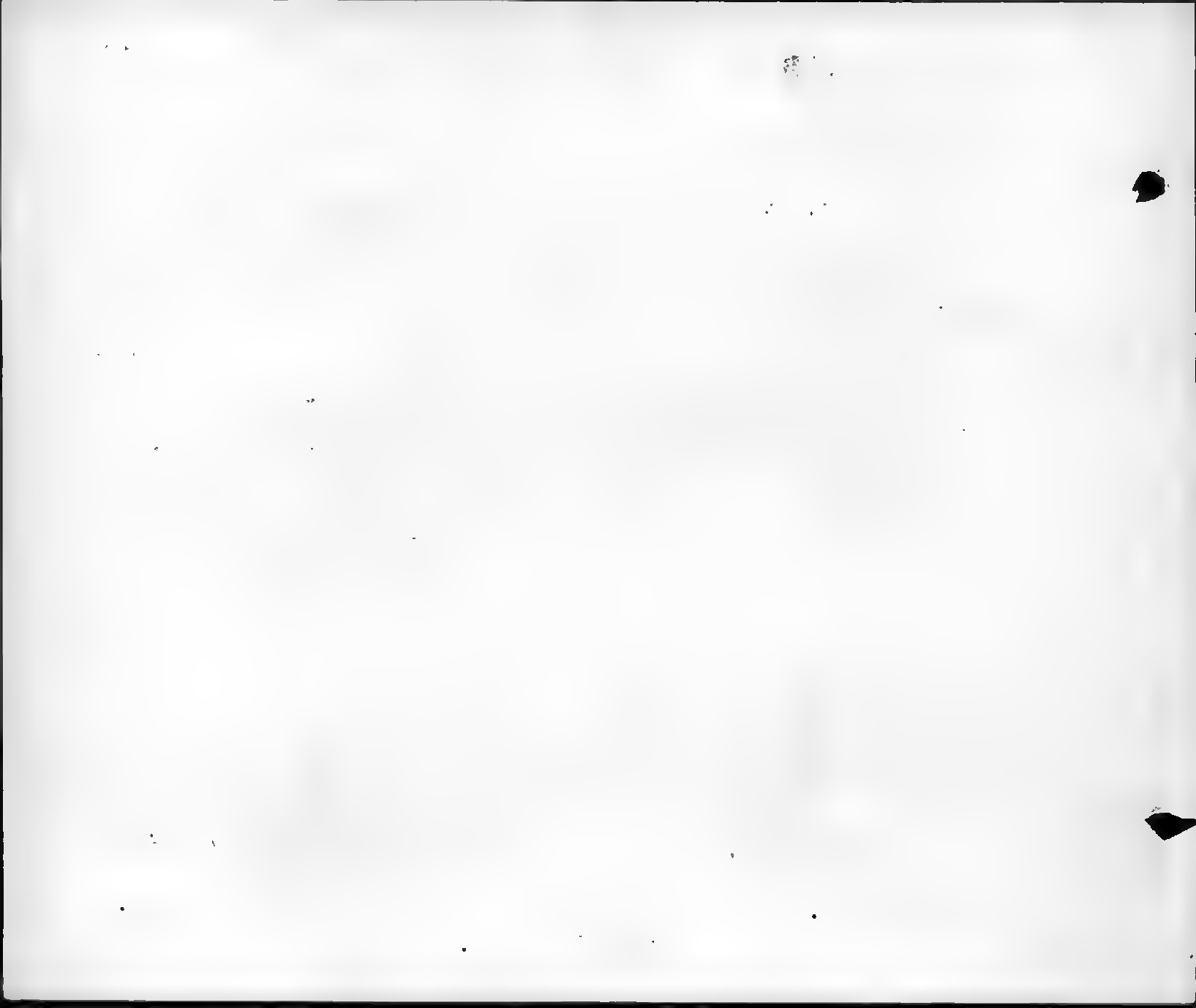
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

958

68951

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Res'dence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			
f. STREET ADDRESS SOUTH LAWN LANE				g. IS RES'DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ABIGAH Middle CALVIN Last WILDER				4. DATE OF DEATH Month JANUARY Day 4 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/31/60	
9. AGE (In years last birthday) - yrs		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.		11. IF UNDER 24 HRS. Months 3 Days 3 Hours 3 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME THOMAS CALVIN WILDER				14. MOTHER'S MAIDEN NAME BETTY ANN SUDDUETH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) NO				16. SOCIAL SECURITY NO None			
17. INFORMANT HOSPITAL RECORDS, OLNEY, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 760.0.0 DUE TO right left frontal lobe Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/31 19 60 to Jan 4 19 61 , that (I) (we) last saw the deceased alive on Jan 4 19 61 , and that death occurred at M , from the causes and on the date stated above							
22a. SIGNATURE A. D. Bonifant M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) A. D. Bonifant M.D.				22d. ADDRESS Sandy Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 5 1961			
23c. NAME OF CEMETERY OR CREMATORY Seal Farm				23d. LOCATION (City, town, or county) (State) Etchison Md.			
24. FUNERAL DIRECTOR'S SIGNATURE James Barber				25a. REC'D BY REGISTRAR Laytonsville Md.			
25b. REGISTRAR'S SIGNATURE James L. Thomas				25c. DATE JAN 11 '61			

MEDICAL CERTIFICATION

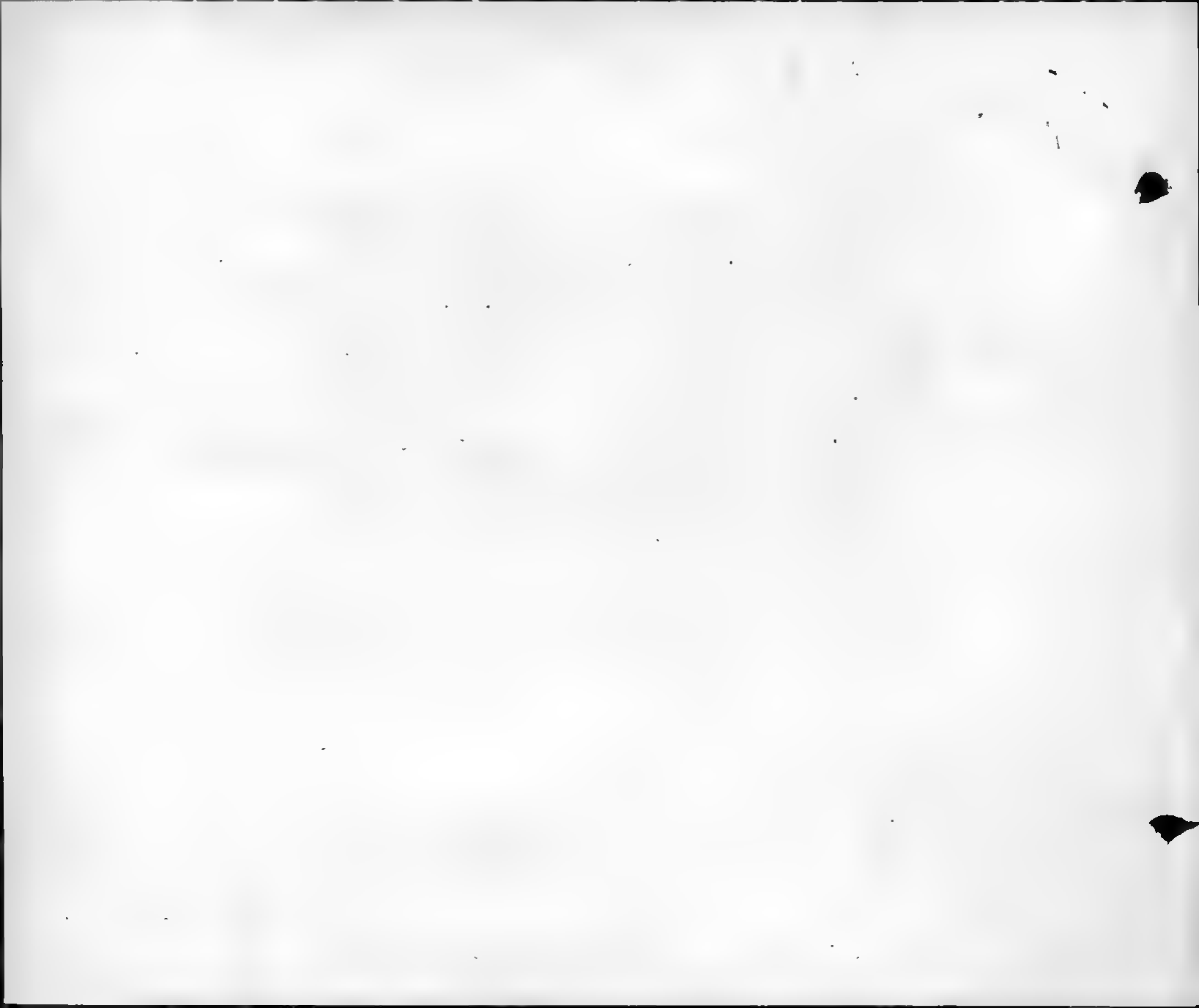


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1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4822 Morgan Drive				d. STREET ADDRESS 4822 Morgan Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DURWOOD R. WILLIAMS				4. DATE OF DEATH Month Jan. Day 28, Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 8, 1894	
9. AGE (In years last birthday) 66 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Samuel G. Williams				14. MOTHER'S MAIDEN NAME Wilhelm Belcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO WW I 241-12-9996		17. INFORMANT Wife Margaret G. Williams		Address Same as Item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 10 YR (c) 10 YR							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1950 to Jan 1961 , that (I) (we) last saw the deceased alive on Jan 26 1961 , and that death occurred at 1 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Leo I. Donovan MD				22b. ADDRESS 214 Wisc Ave Bethesda MD		22c. PHYSICIAN'S NAME (Type) LEO I DONOVAN MD	
22d. PHYSICIAN'S NAME (Type) LEO I DONOVAN MD		22e. ADDRESS 214 Wisc Ave Bethesda MD		22f. (City or town) (County) (State)		22g. DATE SIGNED 1/29/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-1-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR FEB 2 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thrall			



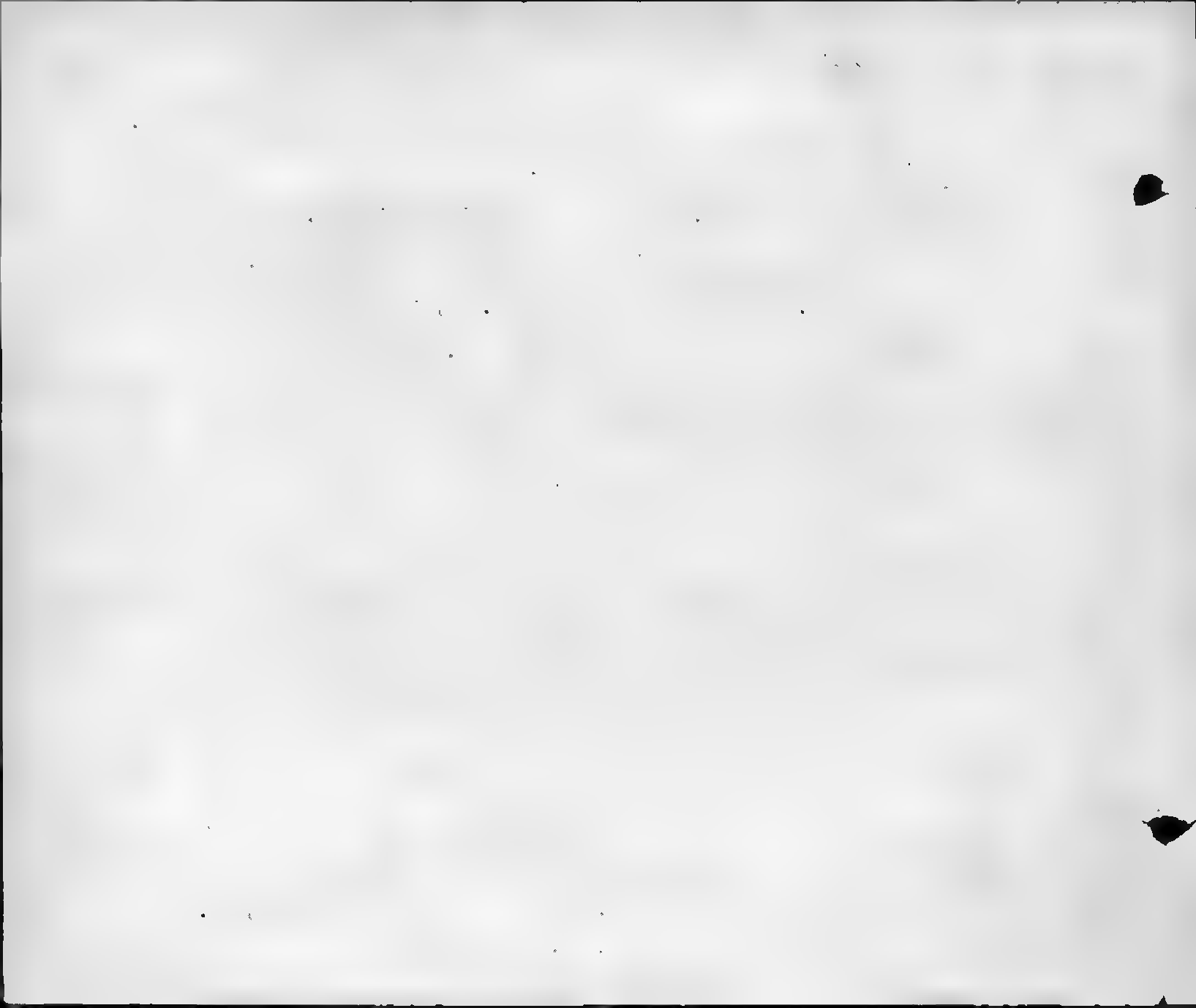
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
960									
60953									
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Kensington		c. LENGTH OF STAY IN 1b 6 hrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Kensington		d. STREET ADDRESS		3910 Hampton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		John Henry Williams		4. DATE OF DEATH		Jan. 30		19 61	
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		Aug. 14, 1890	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		Va.	
13. FATHER'S NAME		John Williams		14. MOTHER'S MAIDEN NAME		Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Thelma Williams (wife)		Item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH		sudden	
DUE TO		(b)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		ASSTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
ACTUAL SIGNATURE		Frank J. Proschart		M D		1/31/61			
EXAMINER'S NAME (Type)		Frank J. Proschart		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial		2/4/61		Elijah,		Poolesville, Md.			
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Snowden Funeral Home,		Rockville, Md.		FEB 2 61		Arthur S. Thomas			
				DATE					

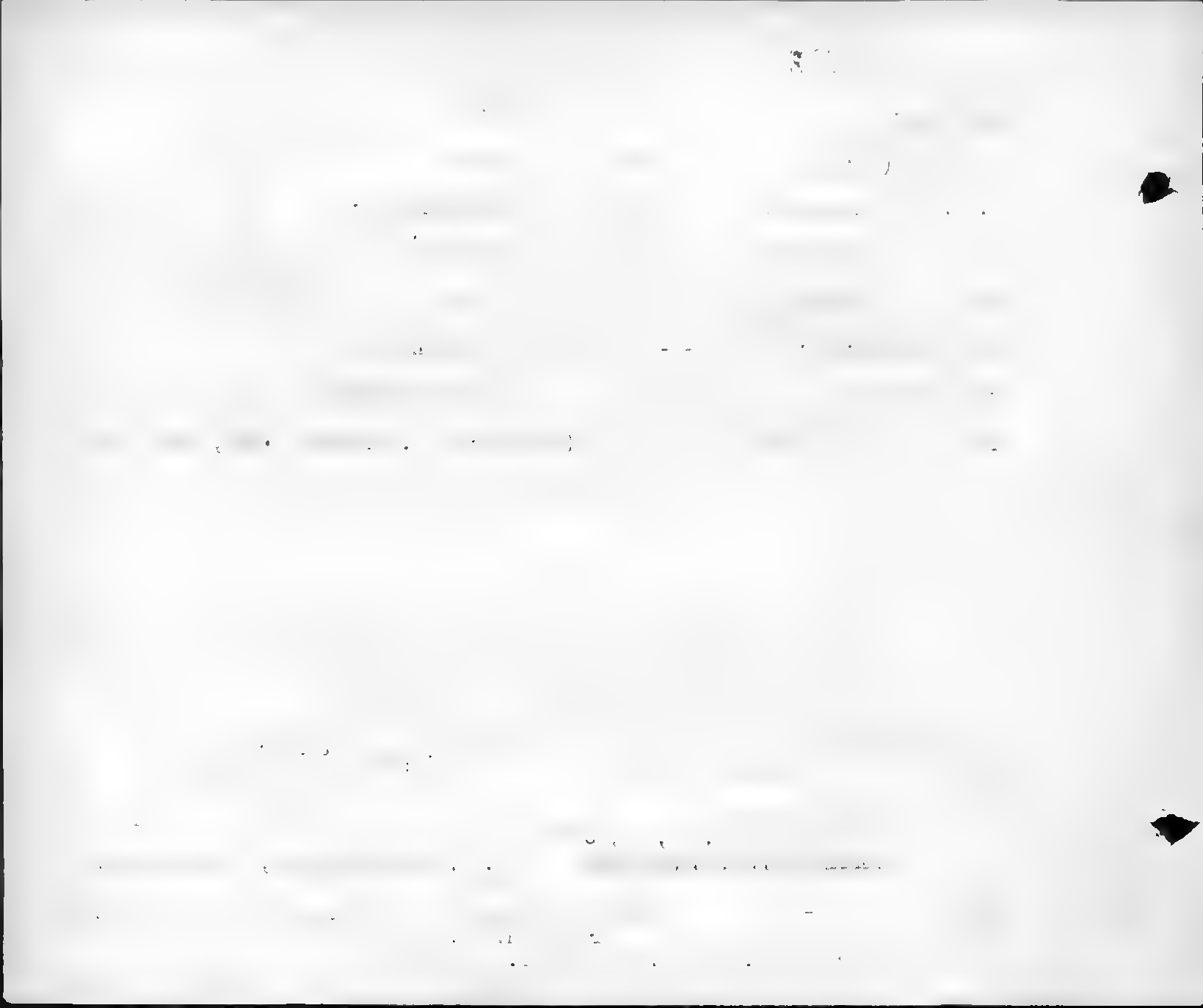


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06954

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 79 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY McLean c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McLean d. STREET ADDRESS 6 Bermuda Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sr. Louis Boisseau WILLIAMS				4. DATE OF DEATH Month Day Year January 4 1961			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-5-95	
9. AGE (In years last birthday) 65 yrs		10. FL UNDER 1 YEAR Months Days 65		11. IF UNDER 24 HRS Hours Min. 65		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Green WILLIAMS				14. MOTHER'S MAIDEN NAME Pauline DENNIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes 1910 to 1913				16. SOCIAL SECURITY NO 564-14-7675		17. INFORMANT (S) Major L. B. Williams, USAF, same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199.2 Metastatic Carcinoma (Primary Unknown) DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Cirrhosis, Hepatic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis, Hepatic				INTERVAL BETWEEN ONSET AND DEATH 1 yr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 17 1960 to January 4 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 4 1961 , and that death occurred at 10:35 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>John Wood Davis</i> John Wood DAVIS, LT, MC, USN				22b. DATE SIGNED 1-5-61			
22c. PHYSICIAN'S NAME (Type) John Wood DAVIS, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-9-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Morris</i> Arlington Funeral Home, 3901 N. Fairfax Dr.				25a. REC'D BY REGISTRAR DATE JAN 9 '61		25b. REGISTRAR'S SIGNATURE <i>John S. Kane</i>	



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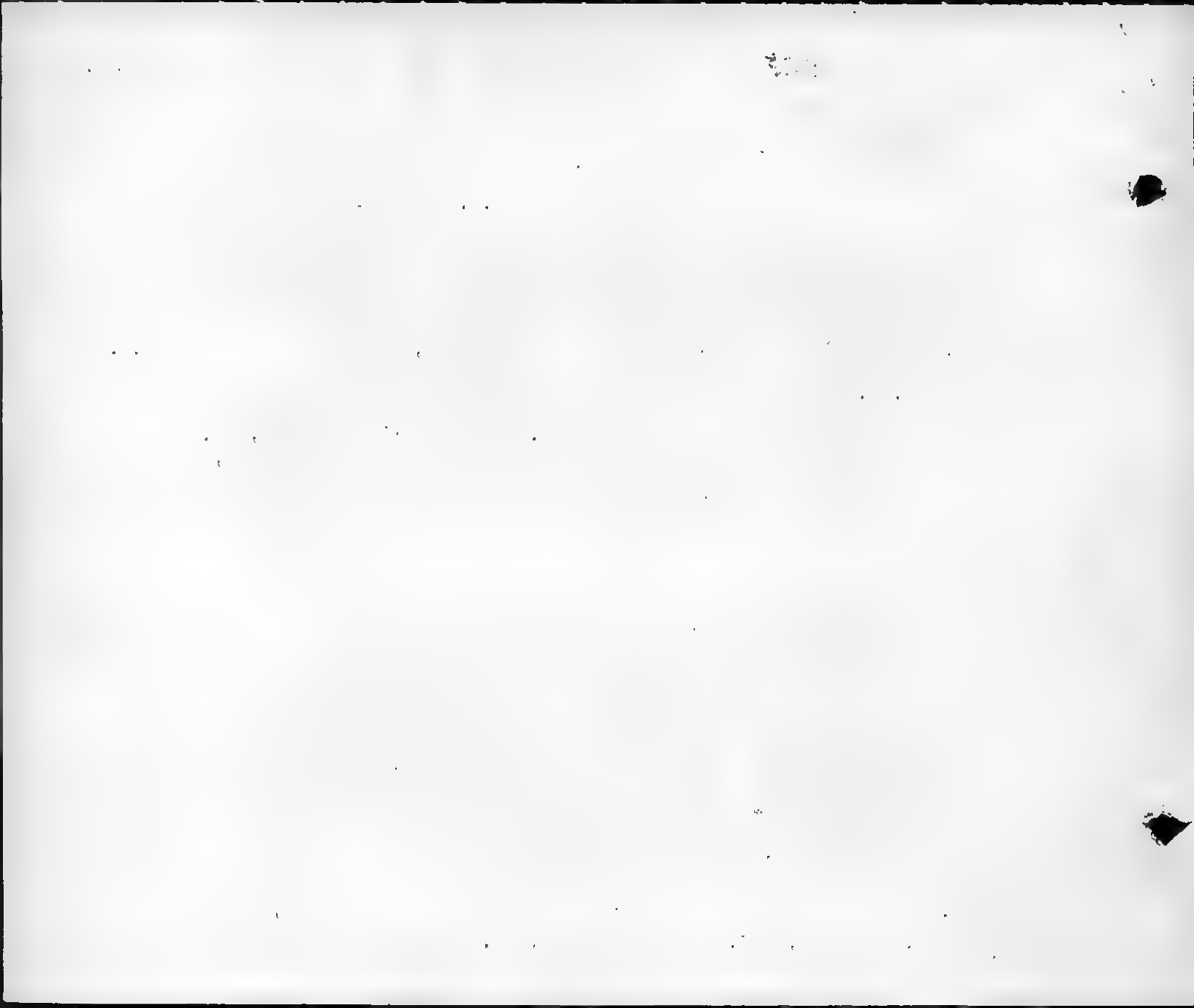
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962

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60955

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403 Waterford Road		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE TEXAS b. COUNTY SHERMAN c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHERMAN d. STREET ADDRESS P.O. Box 697, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LUTHER Middle EDGAR Last WILLIAMS		4. DATE OF DEATH Month 1 Day 6 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/83
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15	11. IF UNDER 24 HRS Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY TIRE RECAPPING	11. BIRTHPLACE (State or foreign country) GRAHAM, VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE M. D. WILLIAMS	
14. MOTHER'S MAIDEN NAME SARAH EPPERLY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Willie Myrtle Williams, PO. Box 697 Sherman, Texas	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal Insufficiency DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Sept. 1960 to Jan. 1961 , that (I) (we) last saw the deceased alive on Jan 6 1961 , and that death occurred at 11:25 M, from the causes and on the date stated above	
22a. SIGNATURE Bernard A. Fitzgerald M.D.		22b. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD	
22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED 1-7-61	
22e. ADDRESS 217 University Blvd E SS, Md		22f. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) TRANS. & BURIAL 1/11/61		23b. DATE THEREOF 1/11/61	
23c. NAME OF CEMETERY OR CREMATORY WEST HILL CEMETERY		23d. LOCATION (City, town, or county) (State) SHERMAN, TEXAS	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		25a. REC'D BY REGISTRAR JAN 11 '61	
25b. REGISTRAR'S SIGNATURE William S. Kraw		25c. REGISTRAR'S SIGNATURE	



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

963
CERTIFICATE OF DEATH

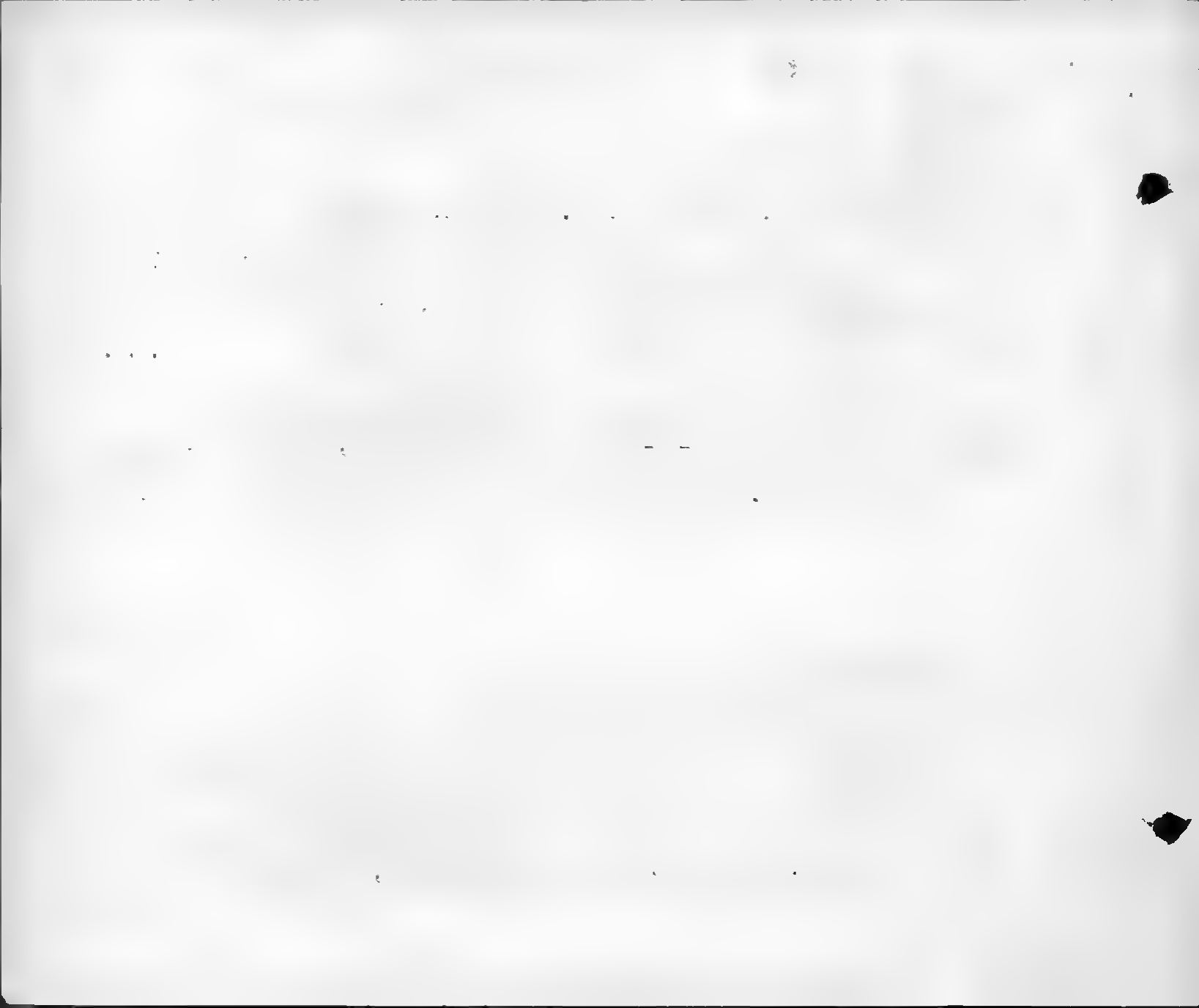
Reg. Dist. No.

00956

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE North Carolina b. COUNTY Burnsville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burnsville d. STREET ADDRESS Route 4, Box 139 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last David Garrett Wilson			4. DATE OF DEATH Month Day Year January 7 1961				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1906		9. AGE (In years last birthday) yrs 54		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) North Carolina			
13. FATHER'S NAME Turner Wilson			14. MOTHER'S MAIDEN NAME Martha Hensley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 238-26-2433		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastases 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Choriocarcinoma DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1-2 weeks 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January 5 , 19 61 , to January 7 , 19 61 , that I last saw the deceased alive on January 7 , 19 61 , and that death occurred at 9:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1/7/61 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Michael Z. Lazor M.D.		PHYSICIAN'S NAME (Type) MICHAEL Z. LAZOR, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-12-61	22c. NAME OF CEMETERY OR CREMATORY Upper Egypt Township		22d. LOCATION (City, town, or county) (State) Burnsville N.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey, Bethesda, Md.			24a. REC'D BY REGISTRAR DATE JAN 10 '61		24b. REGISTRAR'S SIGNATURE Carroll S. Kneass		

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00957

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hosp. 1100 Devere Dr</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>15</u>			
3. NAME OF DECEASED (Type or print) <u>Lizzie Mae Wilson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1961</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-94</u>	9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR: Months <u>66</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>			
13. FATHER'S NAME <u>Abe Crosby</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Pettis</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hilda Champion</u> <u>Margaret Pettis</u> <u>1100 Devere Dr</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (e), stating the underlying cause last. DUE TO (c) <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>1</u> Day <u>30</u> Year <u>61</u> Hour <u>0</u> a.m. <u>0</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-26-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-30-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Road</u>			
22d. LOCATION (City, town, or country) <u>Rockville Md</u>		22e. (State) <u>MD</u>		22f. (County) <u>Montgomery</u>			
23. FUNERAL DIRECTOR <u>Deaf Funeral Home</u>		ADDRESS <u>4812 Haverhill</u>		24a. REC'D BY REGISTRAR <u>WASH DC</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>		DATE <u>FEB 6 '61</u>		24c. (City or town)			

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

965

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MAYNARD CLARK WIMS
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60958

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>104 North Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>104 North Rockville</u>			
c. LENGTH OF STAY IN 1b <u>5 yrs.</u>				d. STREET ADDRESS <u>104 North Rockville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Maynard Clark Wims</u>				4. DATE OF DEATH <u>Jan. 16, 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 3, 1895</u>	
9. AGE (In years, last birthday) <u>65</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Land scaper</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN WIMS</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Hutchinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Wife: Martha Wims, 104 North Rockville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>177X</u> DUE TO <u>Broncho-Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Pulmonary Ca.</u> DUE TO (c) <u>Prostatic Adenocarcinoma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>4 mos.</u> <u>2 yrs.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 16, 1961</u> to <u>Jan. 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan. 16, 1961</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.				22a. SIGNATURE <u>Clive B. Jackson, M.D.</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> DATE <u>1-16-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Clive B. Jackson, M.D.</u>				22d. ADDRESS <u>202 Martin Ln., Rockville, Md.</u>			
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF <u>1/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley..</u>		23d. LOCATION (City, town, or county) (State) <u>Pocky Hill, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 26 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Walter S. Kimes</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

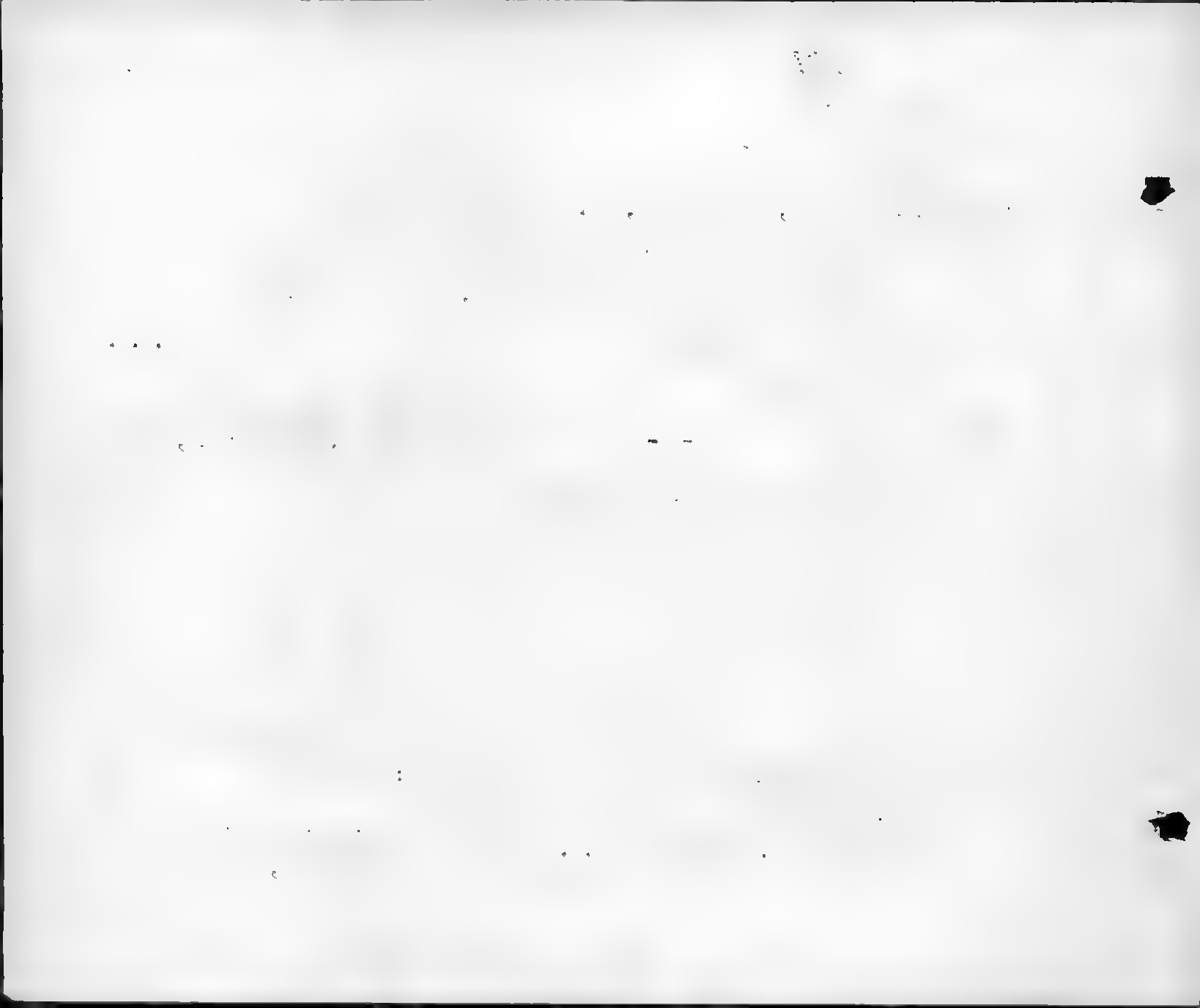
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966

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
				d. STREET ADDRESS 6103 Eastern Avenue			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Joseph First (no middle name) Middle Witcoff Last				4. DATE OF DEATH Month January Day 29 Year 19 61			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1896		9. AGE (In years last birthday) 64 yrs	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Laundrymat Owner		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Samuel Witcoff				14 MOTHER'S MAIDEN NAME Lieby Witcoff			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 231-01-9802		17. INFORMANT The medical Records Address The clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myelogenous Leukemia DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 24 Hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from January 25, 1961 to January 29, 1961 , that (I) (we) lost saw the deceased alive on January 29, 1961 , and that death occurred on 12:15 PM the causes and on the date stated above.							
22a. SIGNATURE Richard E. Rieselbach M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 1/29/61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Richard E. Rieselbach M.D.				22d. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/1/61		23c. NAME OF CEMETERY OR CREMATORY ARL. NAT'L Cem.		23d. LOCATION (City, town, or county) (State) ARL., VA.	
24. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home				ADDRESS 4717-926 0170		25a. REC'D BY REGISTRAR DATE JAN 31 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Finner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete y filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to bur-ol, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 11/59

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

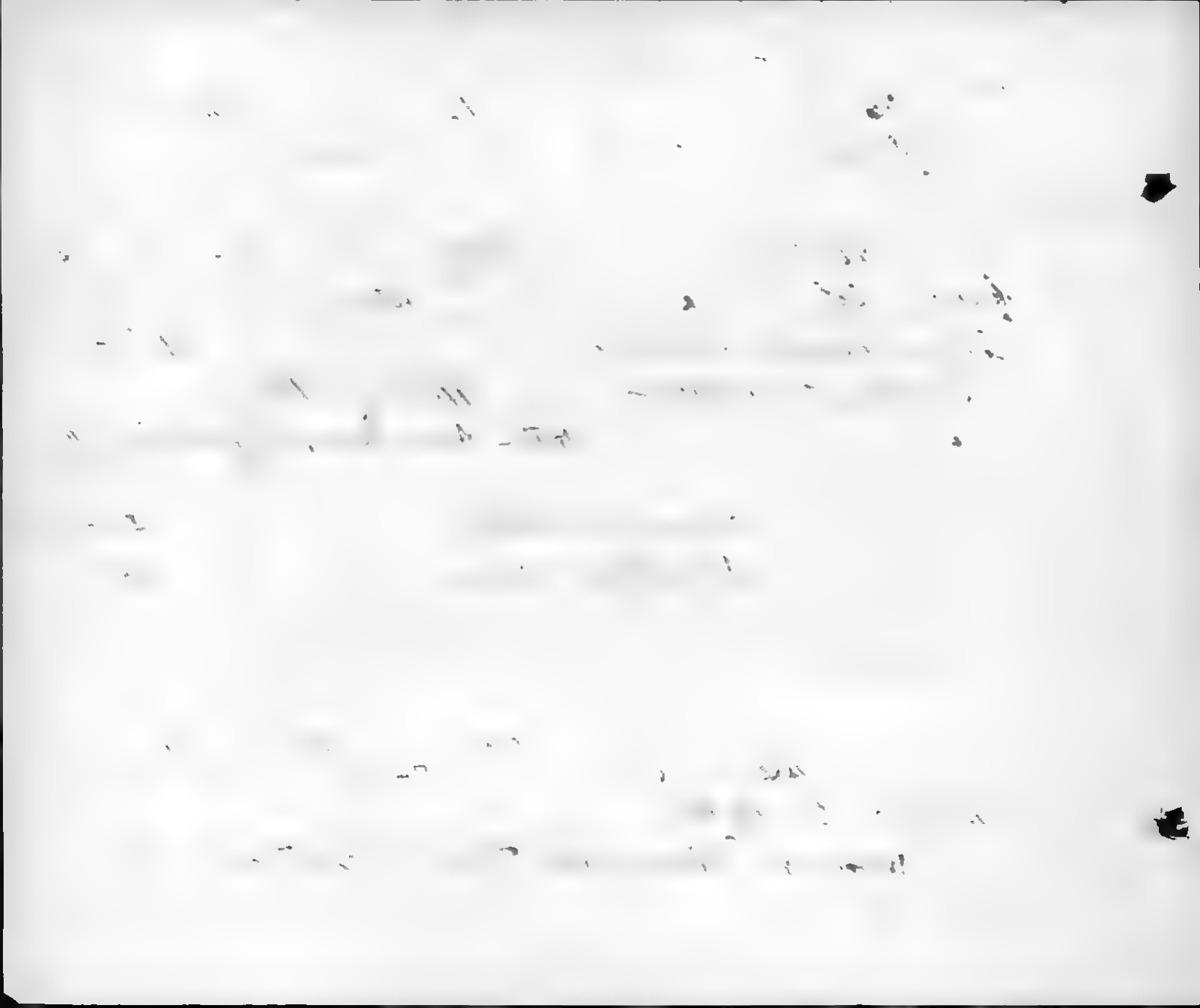
967

CERTIFICATE OF DEATH

66960

Items 1, 11, 11a, 11b, 11c, 11d, 11e, 11f, 11g, 11h, 11i, 11j, 11k, 11l, 11m, 11n, 11o, 11p, 11q, 11r, 11s, 11t, 11u, 11v, 11w, 11x, 11y, 11z, 11aa, 11ab, 11ac, 11ad, 11ae, 11af, 11ag, 11ah, 11ai, 11aj, 11ak, 11al, 11am, 11an, 11ao, 11ap, 11aq, 11ar, 11as, 11at, 11au, 11av, 11aw, 11ax, 11ay, 11az, 11ba, 11bb, 11bc, 11bd, 11be, 11bf, 11bg, 11bh, 11bi, 11bj, 11bk, 11bl, 11bm, 11bn, 11bo, 11bp, 11bq, 11br, 11bs, 11bt, 11bu, 11bv, 11bw, 11bx, 11by, 11bz, 11ca, 11cb, 11cc, 11cd, 11ce, 11cf, 11cg, 11ch, 11ci, 11cj, 11ck, 11cl, 11cm, 11cn, 11co, 11cp, 11cq, 11cr, 11cs, 11ct, 11cu, 11cv, 11cw, 11cx, 11cy, 11cz, 11da, 11db, 11dc, 11dd, 11de, 11df, 11dg, 11dh, 11di, 11dj, 11dk, 11dl, 11dm, 11dn, 11do, 11dp, 11dq, 11dr, 11ds, 11dt, 11du, 11dv, 11dw, 11dx, 11dy, 11dz, 11ea, 11eb, 11ec, 11ed, 11ee, 11ef, 11eg, 11eh, 11ei, 11ej, 11ek, 11el, 11em, 11en, 11eo, 11ep, 11eq, 11er, 11es, 11et, 11eu, 11ev, 11ew, 11ex, 11ey, 11ez, 11fa, 11fb, 11fc, 11fd, 11fe, 11ff, 11fg, 11fh, 11fi, 11fj, 11fk, 11fl, 11fm, 11fn, 11fo, 11fp, 11fq, 11fr, 11fs, 11ft, 11fu, 11fv, 11fw, 11fx, 11fy, 11fz, 11ga, 11gb, 11gc, 11gd, 11ge, 11gf, 11gg, 11gh, 11gi, 11gj, 11gk, 11gl, 11gm, 11gn, 11go, 11gp, 11gq, 11gr, 11gs, 11gt, 11gu, 11gv, 11gw, 11gx, 11gy, 11gz, 11ha, 11hb, 11hc, 11hd, 11he, 11hf, 11hg, 11hh, 11hi, 11hj, 11hk, 11hl, 11hm, 11hn, 11ho, 11hp, 11hq, 11hr, 11hs, 11ht, 11hu, 11hv, 11hw, 11hx, 11hy, 11hz, 11ia, 11ib, 11ic, 11id, 11ie, 11if, 11ig, 11ih, 11ii, 11ij, 11ik, 11il, 11im, 11in, 11io, 11ip, 11iq, 11ir, 11is, 11it, 11iu, 11iv, 11iw, 11ix, 11iy, 11iz, 11ja, 11jb, 11jc, 11jd, 11je, 11jf, 11jg, 11jh, 11ji, 11jj, 11jk, 11jl, 11jm, 11jn, 11jo, 11jp, 11jq, 11jr, 11js, 11jt, 11ju, 11jv, 11jw, 11jx, 11jy, 11jz, 11ka, 11kb, 11kc, 11kd, 11ke, 11kf, 11kg, 11kh, 11ki, 11kj, 11kk, 11kl, 11km, 11kn, 11ko, 11kp, 11kq, 11kr, 11ks, 11kt, 11ku, 11kv, 11kw, 11kx, 11ky, 11kz, 11la, 11lb, 11lc, 11ld, 11le, 11lf, 11lg, 11lh, 11li, 11lj, 11lk, 11ll, 11lm, 11ln, 11lo, 11lp, 11lq, 11lr, 11ls, 11lt, 11lu, 11lv, 11lw, 11lx, 11ly, 11lz, 11ma, 11mb, 11mc, 11md, 11me, 11mf, 11mg, 11mh, 11mi, 11mj, 11mk, 11ml, 11mm, 11mn, 11mo, 11mp, 11mq, 11mr, 11ms, 11mt, 11mu, 11mv, 11mw, 11mx, 11my, 11mz, 11na, 11nb, 11nc, 11nd, 11ne, 11nf, 11ng, 11nh, 11ni, 11nj, 11nk, 11nl, 11nm, 11nn, 11no, 11np, 11nq, 11nr, 11ns, 11nt, 11nu, 11nv, 11nw, 11nx, 11ny, 11nz, 11oa, 11ob, 11oc, 11od, 11oe, 11of, 11og, 11oh, 11oi, 11oj, 11ok, 11ol, 11om, 11on, 11oo, 11op, 11oq, 11or, 11os, 11ot, 11ou, 11ov, 11ow, 11ox, 11oy, 11oz, 11pa, 11pb, 11pc, 11pd, 11pe, 11pf, 11pg, 11ph, 11pi, 11pj, 11pk, 11pl, 11pm, 11pn, 11po, 11pp, 11pq, 11pr, 11ps, 11pt, 11pu, 11pv, 11pw, 11px, 11py, 11pz, 11qa, 11qb, 11qc, 11qd, 11qe, 11qf, 11qg, 11qh, 11qi, 11qj, 11qk, 11ql, 11qm, 11qn, 11qo, 11qp, 11qq, 11qr, 11qs, 11qt, 11qu, 11qv, 11qw, 11qx, 11qy, 11qz, 11ra, 11rb, 11rc, 11rd, 11re, 11rf, 11rg, 11rh, 11ri, 11rj, 11rk, 11rl, 11rm, 11rn, 11ro, 11rp, 11rq, 11rr, 11rs, 11rt, 11ru, 11rv, 11rw, 11rx, 11ry, 11rz, 11sa, 11sb, 11sc, 11sd, 11se, 11sf, 11sg, 11sh, 11si, 11sj, 11sk, 11sl, 11sm, 11sn, 11so, 11sp, 11sq, 11sr, 11ss, 11st, 11su, 11sv, 11sw, 11sx, 11sy, 11sz, 11ta, 11tb, 11tc, 11td, 11te, 11tf, 11tg, 11th, 11ti, 11tj, 11tk, 11tl, 11tm, 11tn, 11to, 11tp, 11tq, 11tr, 11ts, 11tt, 11tu, 11tv, 11tw, 11tx, 11ty, 11tz, 11ua, 11ub, 11uc, 11ud, 11ue, 11uf, 11ug, 11uh, 11ui, 11uj, 11uk, 11ul, 11um, 11un, 11uo, 11up, 11uq, 11ur, 11us, 11ut, 11uu, 11uv, 11uw, 11ux, 11uy, 11uz, 11va, 11vb, 11vc, 11vd, 11ve, 11vf, 11vg, 11vh, 11vi, 11vj, 11vk, 11vl, 11vm, 11vn, 11vo, 11vp, 11vq, 11vr, 11vs, 11vt, 11vu, 11vv, 11vw, 11vx, 11vy, 11vz, 11wa, 11wb, 11wc, 11wd, 11we, 11wf, 11wg, 11wh, 11wi, 11wj, 11wk, 11wl, 11wm, 11wn, 11wo, 11wp, 11wq, 11wr, 11ws, 11wt, 11wu, 11wv, 11ww, 11wx, 11wy, 11wz, 11xa, 11xb, 11xc, 11xd, 11xe, 11xf, 11xg, 11xh, 11xi, 11xj, 11xk, 11xl, 11xm, 11xn, 11xo, 11xp, 11xq, 11xr, 11xs, 11xt, 11xu, 11xv, 11xw, 11xx, 11xy, 11xz, 11ya, 11yb, 11yc, 11yd, 11ye, 11yf, 11yg, 11yh, 11yi, 11yj, 11yk, 11yl, 11ym, 11yn, 11yo, 11yp, 11yq, 11yr, 11ys, 11yt, 11yu, 11yv, 11yw, 11yx, 11yy, 11yz, 11za, 11zb, 11zc, 11zd, 11ze, 11zf, 11zg, 11zh, 11zi, 11zj, 11zk, 11zl, 11zm, 11zn, 11zo, 11zp, 11zq, 11zr, 11zs, 11zt, 11zu, 11zv, 11zw, 11zx, 11zy, 11zz, 11aa, 11ab, 11ac, 11ad, 11ae, 11af, 11ag, 11ah, 11ai, 11aj, 11ak, 11al, 11am, 11an, 11ao, 11ap, 11aq, 11ar, 11as, 11at, 11au, 11av, 11aw, 11ax, 11ay, 11az, 11ba, 11bb, 11bc, 11bd, 11be, 11bf, 11bg, 11bh, 11bi, 11bj, 11bk, 11bl, 11bm, 11bn, 11bo, 11bp, 11bq, 11br, 11bs, 11bt, 11bu, 11bv, 11bw, 11bx, 11by, 11bz, 11ca, 11cb, 11cc, 11cd, 11ce, 11cf, 11cg, 11ch, 11ci, 11cj, 11ck, 11cl, 11cm, 11cn, 11co, 11cp, 11cq, 11cr, 11cs, 11ct, 11cu, 11cv, 11cw, 11cx, 11cy, 11cz, 11da, 11db, 11dc, 11dd, 11de, 11df, 11dg, 11dh, 11di, 11dj, 11dk, 11dl, 11dm, 11dn, 11do, 11dp, 11dq, 11dr, 11ds, 11dt, 11du, 11dv, 11dw, 11dx, 11dy, 11dz, 11ea, 11eb, 11ec, 11ed, 11ee, 11ef, 11eg, 11eh, 11ei, 11ej, 11ek, 11el, 11em, 11en, 11eo, 11ep, 11eq, 11er, 11es, 11et, 11eu, 11ev, 11ew, 11ex, 11ey, 11ez, 11fa, 11fb, 11fc, 11fd, 11fe, 11ff, 11fg, 11fh, 11fi, 11fj, 11fk, 11fl, 11fm, 11fn, 11fo, 11fp, 11fq, 11fr, 11fs, 11ft, 11fu, 11fv, 11fw, 11fx, 11fy, 11fz, 11ga, 11gb, 11gc, 11gd, 11ge, 11gf, 11gg, 11gh, 11gi, 11gj, 11gk, 11gl, 11gm, 11gn, 11go, 11gp, 11gq, 11gr, 11gs, 11gt, 11gu, 11gv, 11gw, 11gx, 11gy, 11gz, 11ha, 11hb, 11hc, 11hd, 11he, 11hf, 11hg, 11hh, 11hi, 11hj, 11hk, 11hl, 11hm, 11hn, 11ho, 11hp, 11hq, 11hr, 11hs, 11ht, 11hu, 11hv, 11hw, 11hx, 11hy, 11hz, 11ia, 11ib, 11ic, 11id, 11ie, 11if, 11ig, 11ih, 11ii, 11ij, 11ik, 11il, 11im, 11in, 11io, 11ip, 11iq, 11ir, 11is, 11it, 11iu, 11iv, 11iw, 11ix, 11iy, 11iz, 11ja, 11jb, 11jc, 11jd, 11je, 11jf, 11jg, 11jh, 11ji, 11jj, 11jk, 11jl, 11jm, 11jn, 11jo, 11jp, 11jq, 11jr, 11js, 11jt, 11ju, 11jv, 11jw, 11jx, 11jy, 11jz, 11ka, 11kb, 11kc, 11kd, 11ke, 11kf, 11kg, 11kh, 11ki, 11kj, 11kk, 11kl, 11km, 11kn, 11ko, 11kp, 11kq, 11kr, 11ks, 11kt, 11ku, 11kv, 11kw, 11kx, 11ky, 11kz, 11la, 11lb, 11lc, 11ld, 11le, 11lf, 11lg, 11lh, 11li, 11lj, 11lk, 11ll, 11lm, 11ln, 11lo, 11lp, 11lq, 11lr, 11ls, 11lt, 11lu, 11lv, 11lw, 11lx, 11ly, 11lz, 11ma, 11mb, 11mc, 11md, 11me, 11mf, 11mg, 11mh, 11mi, 11mj, 11mk, 11ml, 11mm, 11mn, 11mo, 11mp, 11mq, 11mr, 11ms, 11mt, 11mu, 11mv, 11mw, 11mx, 11my, 11mz, 11na, 11nb, 11nc, 11nd, 11ne, 11nf, 11ng, 11nh, 11ni, 11nj, 11nk, 11nl, 11nm, 11nn, 11no, 11np, 11nq, 11nr, 11ns, 11nt, 11nu, 11nv, 11nw, 11nx, 11ny, 11nz, 11oa, 11ob, 11oc, 11od, 11oe, 11of, 11og, 11oh, 11oi, 11oj, 11ok, 11ol, 11om, 11on, 11oo, 11op, 11oq, 11or, 11os, 11ot, 11ou, 11ov, 11ow, 11ox, 11oy, 11oz, 11pa, 11pb, 11pc, 11pd, 11pe, 11pf, 11pg, 11ph, 11pi, 11pj, 11pk, 11pl, 11pm, 11pn, 11po, 11pp, 11pq, 11pr, 11ps, 11pt, 11pu, 11pv, 11pw, 11px, 11py, 11pz, 11qa, 11qb, 11qc, 11qd, 11qe, 11qf, 11qg, 11qh, 11qi, 11qj, 11qk, 11ql, 11qm, 11qn, 11qo, 11qp, 11qq, 11qr, 11qs, 11qt, 11qu, 11qv, 11qw, 11qx, 11qy, 11qz, 11ra, 11rb, 11rc, 11rd, 11re, 11rf, 11rg, 11rh, 11ri, 11rj, 11rk, 11rl, 11rm, 11rn, 11ro, 11rp, 11rq, 11rr, 11rs, 11rt, 11ru, 11rv, 11rw, 11rx, 11ry, 11rz, 11sa, 11sb, 11sc, 11sd, 11se, 11sf, 11sg, 11sh, 11si, 11sj, 11sk, 11sl, 11sm, 11sn, 11so, 11sp, 11sq, 11sr, 11ss, 11st, 11su, 11sv, 11sw, 11sx, 11sy, 11sz, 11ta, 11tb, 11tc, 11td, 11te, 11tf, 11tg, 11th, 11ti, 11tj, 11tk, 11tl, 11tm, 11tn, 11to, 11tp, 11tq, 11tr, 11ts, 11tt, 11tu, 11tv, 11tw, 11tx, 11ty, 11tz, 11ua, 11ub, 11uc, 11ud, 11ue, 11uf, 11ug, 11uh, 11ui, 11uj, 11uk, 11ul, 11um, 11un, 11uo, 11up, 11uq, 11ur, 11us, 11ut, 11uu, 11uv, 11uw, 11ux, 11uy, 11uz, 11va, 11vb, 11vc, 11vd, 11ve, 11vf, 11vg, 11vh, 11vi, 11vj, 11vk, 11vl, 11vm, 11vn, 11vo, 11vp, 11vq, 11vr, 11vs, 11vt, 11vu, 11vv, 11vw, 11vx, 11vy, 11vz, 11wa, 11wb, 11wc, 11wd, 11we, 11wf, 11wg, 11wh, 11wi, 11wj, 11wk, 11wl, 11wm, 11wn, 11wo, 11wp, 11wq, 11wr, 11ws, 11wt, 11wu, 11wv, 11ww, 11wx, 11wy, 11wz, 11xa, 11xb, 11xc, 11xd, 11xe, 11xf, 11xg, 11xh, 11xi, 11xj, 11xk, 11xl, 11xm, 11xn, 11xo, 11xp, 11xq, 11xr, 11xs, 11xt, 11xu, 11xv, 11xw, 11xx, 11xy, 11xz, 11ya, 11yb, 11yc, 11yd, 11ye, 11yf, 11yg, 11yh, 11yi, 11yj, 11yk, 11yl, 11ym, 11yn, 11yo, 11yp, 11yq, 11yr, 11ys, 11yt, 11yu, 11yv, 11yw, 11yx, 11yy, 11yz, 11za, 11zb, 11zc, 11zd, 11ze, 11zf, 11zg, 11zh, 11zi, 11zj, 11zk, 11zl, 11zm, 11zn, 11zo, 11zp, 11zq, 11zr, 11zs, 11zt, 11zu, 11zv, 11zw, 11zx, 11zy, 11zz

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>5 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garthursburg</i> X
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mrs. Green's Nursing Home</i>		e. STREET ADDRESS <i>Rural</i> 1	
3. NAME OF DECEASED (Type or print) <i>Mary</i> First <i>Young</i> Middle <i>—</i> Last <i>Young</i>		4. DATE OF DEATH Month <i>Jan</i> - Day <i>2</i> Year <i>1961</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1875</i>
9. AGE (In years last birthday) <i>85 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse - keeping</i>		12. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
13. FATHER'S NAME <i>Wesley Foreman</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Warren</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Hattie Ann Kimo, R3, Garthursburg, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <i>Cancer of intestine</i> <i>2 years</i>			
(b) DUE TO <i>Multiple sclerosis,</i> <i>years</i>			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1950</i> to <i>Jan - 2 - 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec - 25 - 1960</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>William C. Miller</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>William C. Miller, MD</i>		22d. ADDRESS <i>7 Brook Ave., Garthursburg, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>1/6/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rocky Hill Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Clarksburg, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Mawden</i>		25a. REC'D BY REGISTRAR <i>Rocky Hill</i> DATE <i>JAN 9 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>C. L. S. Kimo</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

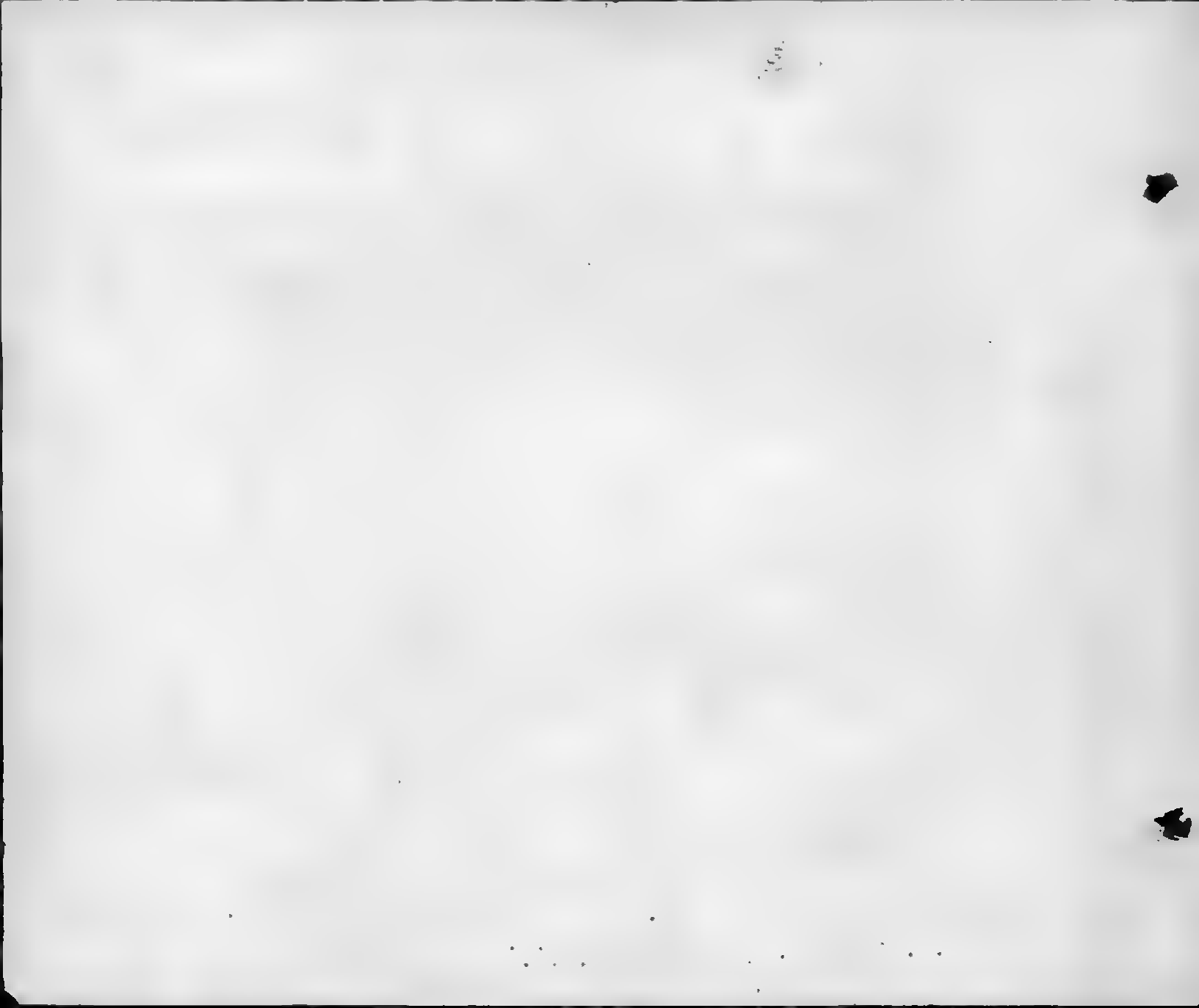
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

968

CERTIFICATE OF DEATH

00961

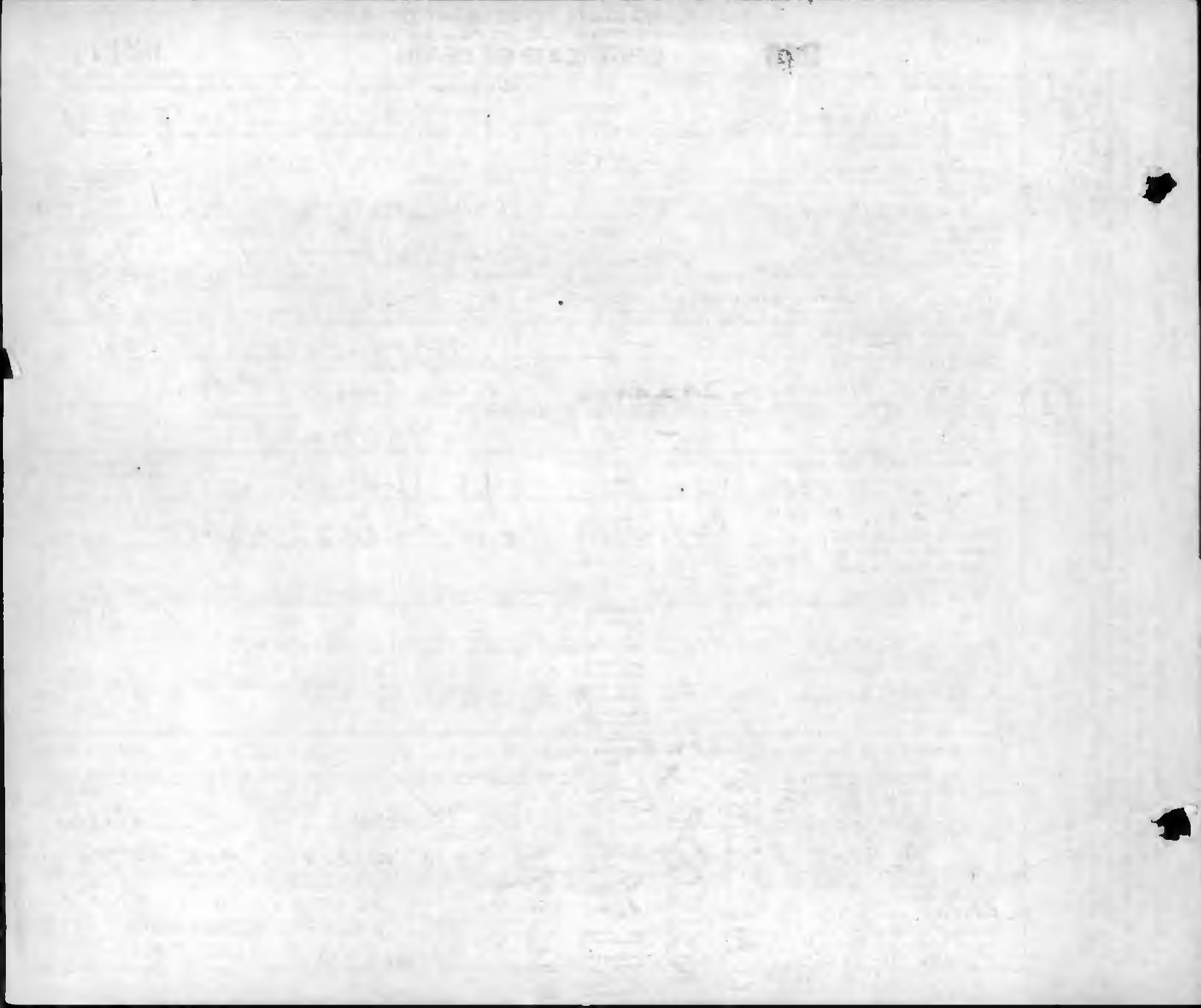
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY (If not in hospital, give street address) <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4502 - 13th Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First Middle Last <u>CLOTILDA</u> <u>ZANE</u>		4. DATE OF DEATH Month Day Year <u>1</u> <u>9</u> <u>1961</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>4-6-86</u>		9. AGE (In years last birthday) <u>74</u> yrs IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>James P. McDonald</u>		14. MOTHER'S MAIDEN NAME <u>Ellen C. Close</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Pt. in Charge - Washington Sanitarium & Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>Previous Thrombosis Left Hemiplegia</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)	
20h. (State)		21. I certify that (I) (this hospital) attended the deceased from 12-28-1960, to 1-9-1961, that (I) (we) last saw the deceased alive on 1-8-1961, and that death occurred at 9:30 A.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>Richard W. Flapp, MD</u>		22b. DATE SIGNED <u>1-9-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard W. Flapp, MD</u>		22d. ADDRESS <u>7666 Carroll Ave Takoma Park, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>1/12/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Dennis Cemetery</u>		23d. LOCATION (City, town or county) <u>Havertown, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>JAN 11 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. ADDRESS <u>Washington 9, D.C.</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>2 HRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				<u>36</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>11714 HATCHER PLACE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BABY</u>		First <u>GIRL</u>		Last <u>ZAZANIS</u>		4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-29-61</u>		9. AGE (In years lost birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JAMES MICHAEL ZAZANIS</u>						14. MOTHER'S MAIDEN NAME <u>MARY EVELYN PITTS</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u>lying cause lost. </div> <div> <u>Premature rupt Membranes</u> <u>Premature labor at 25 weeks</u> </div> <div> INTERVAL BETWEEN ONSET AND DEATH </div> </div>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12</u> to <u>19</u> that (I) (we) lost <u>19</u> saw the deceased alive on <u>19</u> and that death occurred on <u>19</u> at <u>M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Albert S Bright</u>				22b. DATE SIGNED <u>1/29/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>ALBERT S BRIGHT</u>				22d. ADDRESS <u>8218 WISCONSIN AVE BETHESDA</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				23b. DATE THEREOF <u>JAN. 31-'61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>		23d. LOCATION (City, town, or county) (State) <u>OLD GEORGETOWN RD, BETHESDA, MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>SUBURBAN HOSPITAL FOLD GEORGETOWN RD, A. CARTER, ADMINISTRATOR, BETHESDA, M.D.</u>						25a. REC'D BY REGISTRAR DATE <u>FEB 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knease</u>			

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CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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Item 14 43160279 1-10-61 et

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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Manor Sanatorium</i>		d. STREET ADDRESS <i>5515 Hawthorne Pl., N.W.</i>	
3. NAME OF DECEASED (Type or print) First <i>Malcolm</i> Middle <i>Joseph</i> Last <i>Zimmerman</i>		4. DATE OF DEATH Month <i>1</i> Day <i>7</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 17, 1884</i>
9. AGE (In years lost birthday) <i>76 yrs</i>		IF UNDER 1 YEAR Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min.	IF UNDER 24 HRS. Hours <i>1</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Michael P. Zimmerman</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Myers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>A</i>	
17. INFORMANT <i>Mr. Clarence Zimmerman</i>		Address <i>5515 Hawthorne Pl., Wash. D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> 1 year DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>June 10</i> to <i>June 7</i> , 19 <i>61</i> , that (I) (we) lost saw the deceased alive on <i>June 7</i> , 19 <i>61</i> , and that death occurred at <i>3:45 PM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Andrew E. Rudnith</i>		22b. DATE SIGNED <i>11/1/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>ANDREW E. RUDNITH</i>		22d. ADDRESS <i>1120 MacArthur Blvd. W. 466</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/10/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Shanestown</i>		23d. LOCATION (City, town, or county) (State) <i>Clear Spring, Md. D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Fred W. Kraus</i>		ADDRESS <i>Hagerstown, Md</i>	
25a. REC'D BY REGISTRAR <i>DATE JAN 11 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	



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